Health Committee
Meeting 17
Document 37

OFFICE OF THE COMMISSIONER FOR THE PROMOTION OF RIGHTS OF PERSONS WITH MENTAL DISORDERS

Annual Report 2014

28th February 2015

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Foreword

In the third full year of operation the Office is proud to see that as a result of its efforts at mobilising synergies and managing divergent opinions, it has played a vital role in the entry into force of the Mental Health Act, 2012 in its entirety. Although it is envisaged that the full effect of the changes that emanate from the new law will be in place in four (4) years' time, it is encouraging that in the preceding months and in the first few weeks of full entry into force, a number of changes have already been implemented. The Office has progressively developed the necessary infrastructure to effectively implement its assigned responsibilities as the authority to promote and protect the rights and interests of persons with mental disorders in Malta and Gozo.

This report demonstrates the breadth of work performed by the small and multi-skilled team at the Office in 2014. I am personally indebted to each of them for the achievements outlined in this report. Through their hard work and professionalism, this Office has provided effective strategic leadership in ascertaining that the rights of persons with mental disorders are protected and upheld. This positive experience should provide valid insights to the successful implementation in the coming years of the Patients' Charter of Rights.

It is essential that work on the actual implementation of the Mental Health Act and Guardianship legislation is now followed up with further legislative tools. The seminar held last February on the state of mental capacity legislation in Malta demonstrated the importance of tackling lasting powers of attorney, advanced directives, living wills, and assisted decision making. The eventual decision to use these legislative tools must be underpinned by the most fundamental right - human dignity is inviolable and must be respected and protected.

Consideration should be given to the establishment at national level of the Office of the Public Guardian as a watchdog authority to oversee care orders, tutorship, curatorship, guardianship, administrators of benefits and to support decisions of professional staff.

Proper acute care to children, adolescents and youths with acute psychiatric problems needs radical decisions. Within a proper acute care environment, there is the need to provide safe seclusion facilities to avoid the need to care for youngsters on adult wards. I have challenged the Parliamentary Committee on Health to consider moving acute psychiatry services for children, adolescents and youth to Mater Dei Hospital once the Paediatric Oncology service migrates. Young people with challenging behaviour have the right to adequate aftercare and rehabilitation in the community leading to their social integration. Our recommendation remains that this is best achieved through specific supervised residential facilities in the community.

The new Mental Health Act should be viewed by policy makers as a catalyst for change. The provision of quality care that responds to the needs of the person with mental disorder requires one of the biggest challenges, that is, to sift and sort out the acute care, the rehabilitation care, the specialist care and the residential care which is all being delivered sometimes without borders or parameters within the derelict ward environment of Mount Carmel Hospital. In my view, acute psychiatric care of persons with mental disorders should follow the modern trend and move to Mater Dei Hospital. This will also be useful in providing psychiatric care to persons suffering from acute medical conditions.

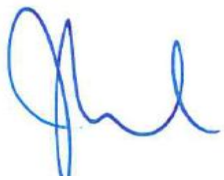
Rehabilitation and specialist care should also move to specialised units in the community supported by residential long term accommodation for those who unfortunately do not make it through rehabilitation. Mount Carmel Hospital should specialise in old age psychiatry and dementia. The geographical spread of community support services is currently uneven, and more psychiatrically trained staff is required to strengthen community support for patients, families and carers.

Mental health must be mainstreamed within and outside health care settings: disease prevention, health promotion, primary care, hospital care, education, housing, social welfare, social security, employment, youth programmes, correctional services, probation service. Sustainable employment prospects for persons with mental disorders are poor. There is a very high economic cost tied to mental health problems in terms of reduced quality of life, loss of productivity, and premature

mortality. During 2015 the Office will continue to uphold these principles and look further into new areas such as mental health and the workplace; mental health in cancer patients and their families; and the possible links between obstetric history and the mental health of children.

During 2014 we have developed a proposal for the setting up of a Mental Health and Well-being Research Trust Fund. Our partners were the University of Malta and RIDT. Following an extensive brainstorming and prioritisation exercise, three initial research priorities were identified. We are proposing translational research into the challenges for the mental health and well-being of: unaccompanied asylum seekers aged 23 years or less; the families and survivors of sudden unexpected or violent deaths; and the long term unemployed. The proposal was forwarded to the Ministry for consideration and funding but there was no commitment to funding in the budgetary allocation to the Office for 2015. Throughout the coming year, the Office intends to continue exploring avenues of possible partnerships that can support and fund this research initiative.

The burden of mental disorders is increasing exponentially with the modernisation of our society and those who are not coping with this burden merit active consideration and support. Maximisation of the potential of persons with mental disorders is not only a question of social justice but also critical for the sustainability of our health system and the prosperity of our society. This Office will continue to provide a voice to vulnerable persons with mental disorders.



Dr John M. Cachia — 28th February 2015

Commissioner

Chapter 1: Background

Introduction

The Commissioner for the Promotion of Rights of Persons with Mental Disorders is established in Article 5 of the Mental Health Act. Appendix 1 lists all the functions assigned to the Commissioner by the Act. This report covers the performance of the Office of the Commissioner from 1st January 2014 up to the 31st December 2014 and is being drawn up in accordance with Article 6 (1) (n) of the Mental Health Act, 2012.

The Office is proud to see that as a result of its efforts at mobilising synergies and managing divergent opinions, it has played a vital role in the entry into force of the Mental Health Act, 2012 as provided in Legal Notice 276 of 2013 and the whole Act was completely in force on 10th October 2014, together with the repeal of the old Act. The Office acknowledges the unconditional effort of all stakeholders at political and service management and delivery levels to meet the deadline. The expected teething problems are being expertly managed and the transition to the new arrangements is ongoing as this report is being drawn up.

The Office welcomes the setting up of the Guardianship Board in August 2014. Guardianship is an option which provides a less stringent substitute decision making regime for vulnerable persons which is proportional to the level of capacity of the individual. The introduction of guardianship must now be followed through with active promotion of the concept with patients, families, carers, health and care professional staff, the Judiciary, lawyers and notaries. This Office is not satisfied with the level of public information and dissemination among professionals regarding guardianship procedures and has repeatedly brought this to the attention of the Registrar.

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. This positive experience should provide valid insights to the successful implementation in the coming years of the Patients' Charter of Rights emanating from the Health Act of 2013.

This Office has continued to provide a voice to vulnerable persons with mental disorders. Maximisation of the potential of persons with mental disorders is not only a question of social justice but also critical for the sustainability of our health system and the prosperity of our society. The burden of mental disorders is increasing exponentially with the modernisation of our society and those who are not coping with this burden merit active consideration and support.

Strategic Approach

This Office places persons with mental disorder at the centre of its activities, empowering them, and their families and carers as valued members of society and as active participants in the care process where relevant.

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.

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.

The ultimate vision of this Office is that of an all-inclusive society, wherein persons with mental disorder are fully empowered to maximise their health, to contribute actively to the community in all spheres of life, including but not limited to the labour market, and wherein the sustainability and prosperity of the social community at large will be positively enhanced.

Organisational set-up

The organisational set-up of the Office as on 31st December 2014 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 Rose Curmi, Officer in Grade 5, Head of Administration
- Ms Natasha Barbara, Assistant Director, Research, Policy Review and Investigation
- Dr Antonella Sammut, Resident Specialist in Public Health Medicine
- Dr Stephen Zammit, Legal Officer
- Ms Gertrude Buttigieg, Principal Speech & Language Pathologist responsible for Communications
- Ms Mariella Maurin, Assistant Principal
- Mr Emanuel Zammit, Messenger/Driver

Vacancies as on 31st December 2014 in order of priority

- Case Management Officer – Health Care Professional (Scale 7-9) - 1
- Statistics and Research Officer (Scale 10) - 1
- Clerical Staff (Scale 14) - 1
- Expert Services (in the area of accountancy and audit) – contract for service

Management Committee Meetings

Management Committee Meetings were held on a regular basis. During 2014 a total of eighteen meetings were held as follows: 10th January 2014, 30th January 2014, 27th February 2014, 14th March 2014, 26th March 2014, 27th March 2014, 3rd April 2014, 24th April 2014, 21st May 2014, 24th June 2014, 22nd July 2014, 10th September 2014, 14th October 2014, 6th November 2014, 11th November 2014, 12th November 2014, 25th November 2014 and 26th November 2014. All the March meetings were largely dedicated to issues related to the implementation of the Mental Health Act whilst all November meetings were largely dedicated to the development of internal Standard Operational Procedures.

The Agenda up to end 2014

In 2013, this Office set out an elaborate work agenda to determine its priorities up to end 2014 and instituted the driving force to steer it on its way through the recruitment of a professional team which has managed to obtain results and bring out added value to the rights and welfare of persons with mental disorders. We live in a society in which the burden of mental disorder appears to continue to be on the rise. Demographic changes have brought about lower fertility rates and longer life expectancies which are shifting and increasing the burden of frailty and dependency. Employment patterns are altering the caring options within families. The challenges of economic dependencies and poverty risks associated with mental disorder are well known. The main areas of attention and the strategic priorities for the Office to secure progress in this challenging agenda are:

Areas of attention	Strategic priorities
Empowerment of persons with a mental disorder as valued members of society	Education of persons with a mental disorder on their rights, responsibilities and to maximise their potential. Training and retraining to acquire the necessary skills for independent living and to be healthy and active members of society
Empowering service users, their families and carers as active participants in the care process	Support representation of service users, their families and carers in strategic and policy initiatives, consultations, inspection, research and evaluation so as to ensure their involvement in policy and planning. Ensuring care plans are drawn up and that service users and their families and carers are involved in individual care plans
Defence of human rights and best interests	Commitment to human rights embedded in all aspects of our work, in service

	providers' policy and practice and in the wider societal context
Quality, compliance and best international standards and practices	Enhance compliance and commitment to continuous quality improvement
Advocacy	Address the needs and rights of vulnerable persons in an integrated and cohesive manner
Influencing policy	Policies aligned to best practices and intersectoral joint action
Working in partnership with key actors and facilitating synergic action	Build and work through a comprehensive network of stakeholders from the public, private, church and social sectors
Organisational efficiency and work ethics	Ensure that the Office works efficiently through the availability of professional and support staff having the necessary skills and expertise to implement the mandate of the Office and deliver a quality service. Ensure commitment to equal opportunities and equal treatment irrespective of age, gender, race, ethnicity, creed, religion, political affiliations, marital status, parental status, disability, sexual orientation or socio-economic situation.
Accessibility	Make our office accessible to our clients and provide our services in a client friendly and professional way

Whilst recording satisfactory progress in most of the areas of attention and strategic priorities listed above, in 2015 the Office will review this agenda and in order to continue to be aligned with the needs and aspirations of these vulnerable members of our society.

Chapter 2: Performance

The main areas of performance which the Office has undertaken throughout 2014 can be grouped under the following headings:

- Implementing the Mental Health Act within the Office
- Influencing Legislation
- Influencing Policy
- Investigation of complaints
- Visits, investigations and audits
- Working in partnerships through:
    - Meetings
    - Working together on specific actions
    - Conferences, seminars, workshops and other events

Implementing the Mental Health Act within the Office

The Mental Health Act 2012 came fully into force on 10th October 2014 accompanied by the total repeal of the Old Act (Chapter 262) and the dissolution of the Mental Health Review Tribunal. Chapter 525 of the Laws of Malta is now the legislation which regulates the provision of mental health services, care and rehabilitation whilst promoting and upholding the rights of people suffering from mental disorders. Through Legal Notice 276 of of September 2013, approximately half of the provisions of the Act were in force throughout 2014. The new articles which came in force in October 2014 include the regulation of voluntary inpatient care, the new procedures and reduced timeframes to be followed for involuntary inpatient care, the introduction of involuntary care in the community, and the protection of persons with mental disorders who have lack of mental capacity. The Act outlines the special involuntary care needs of minors, provides revised procedures concerning patients involved in criminal proceedings, and clarifies various issues related to assistance by police authorities in cases involving persons with mental disorders.

This meant that sixteen new schedules accompanying the Act also came into force. This entailed a number of administrative and operational changes to align the work

of the various officers with the obligations and timeframes that the Act places on the Commissioner.

Development of Standard Operational Protocols (SOPs)

In order to ensure consistency in carrying out the necessary actions involved in the receipt, registration, and approval or otherwise of the various applications or notifications, and in order to ensure that the necessary monitoring and follow-up of outcomes was carried out effectively, consistently and in a timely manner, the Office embarked on the development of Standard Operational Protocols (SOPs). In all, 14 new SOPs were drafted and a fifteenth SOP which was already in force was revised. All 15 SOPs were reviewed and discussed with all officers within the Office and the process was concluded and signed off in early December 2014. In the absence of a dedicated IT system, these SOPs were saved onto a shared server space for ease of reference by all staff officers.

Mental Health Database Monitoring and Management System

Despite all repeated requests from 2012 to date, this Office remains without a mental health database to enable it to manage, monitor and follow involuntary admissions and their outcomes in conformity with the requirements of the Mental Health Act.

During 2014, the Office continued to press for funding for a comprehensive IT solution. In July 2014 we were informed that the Ministry was proposing a mental health IT system that addressed the specific needs of both the Commissioner and the service provider with the necessary safeguards and with full respect to separate roles of the two main users. There was repeated input by staff from this Office to broadly explain yet again the complexity of our requirements. Patient flow charts depicting voluntary admissions, involuntary admissions (including for minors), and Community Treatment Orders (CTO) were revised and presented to support our requirements.

By September 2014 it became increasingly obvious that the Office would not have the necessary IT support in place and in time when the Mental Health Act would come into full force in October 2014. Hence an in-house Excel-based database was devised, planned and implemented. This rudimentary and very basic arrangement is

being utilised to register and monitor the outcomes of applications for involuntary admissions for observation, treatment, extension or continuous detention, community treatment, restriction of freedom of communication, lack of mental capacity, and their revocations. This temporary arrangement is also saved onto a shared server space for ease of access by all staff officers involved in the processing of the schedules linked to the Mental Health Act.

Applications processed by the Commissioner

From the date of entry into force till the end of 2014 (10 weeks), the Office received and processed the following applications in terms of the Mental Health Act:

Involuntary Admission for Observation	36 including 1 minor
Involuntary Admission for Treatment Order	12 (10 granted)
Community Treatment Order	2 (2 granted)
Certificate of Lack of Mental Capacity	4 (4 approved)

Of 36 Involuntary Admissions for Observation, 23 (64%) were males and 13 (36%) were females. The age distribution was as follows:

Age	No. (%)
<18 years	1 (3%)
18-25 years	7 (19%)
26-35 years	8 (22%)
36-45 years	6 (17%)
46-55 years	5 (14%)
>55years	9 (25%)

The outcome of these 36 involuntary admissions was:

Discharged	5 (14%)
Switched to Voluntary Care	20 (55%)
Proceeded to Involuntary Admission for Treatment Order	10 (28%)
Proceeded to Community Treatment Order	1 (3%)

Of the 10 Involuntary Admissions for Treatment Order granted by the Office, 70% were males and 30% were females.

The estimated burden of the various disease categories among those requiring involuntary admission for observation was as follows:

Disease Category	Approximate burden
Organic, including symptomatic, mental disorders	8%
Mental and behavioural disorders due to psychoactive substance use	25%
Schizophrenia, schizotypal and delusional disorders	31%
Mood [affective] disorders	28%
Neurotic, stress-related and somatoform disorders	3%
Behavioural and emotional disorders with onset usually occurring in childhood and adolescence	6%

Although this is very scanty data based on less than 3 months of implementation of the new Mental Health Act, certain trends are already evident. The gender ratio is two males for one female, reflecting expected gender trends for mental disorder incidence. 60% of admissions involve early adulthood and middle aged persons, confirming the high burden of mental disorder in youth and persons aged less than 45 years. It is encouraging to note that 70% of involuntary admissions were either discharged or continued to receive inpatient care on a voluntary basis and only 30% required further treatment against their will. This Office shall be investigating further the level of awareness of patients' rights in terms of the Act, particularly in the case of those patients who are admitted for observation against their will, but who within 10 days are deemed to be willing to continue to receive inpatient care on a voluntary basis.

Mental Health Review Tribunal

On 3rd October 2014 a meeting was held with the Chairman of the Mental Health Review Tribunal, which would cease to function following the repeal of the Old Act. The meeting focused on the hand-over from the Tribunal of pending cases. Due to the sudden demise of the Chairman, the eventual hand-over of the pending files was completed in early January 2015. The new procedure for handling of any pending

cases and eventual requests for reviews of cases either by the Minister for Justice or by the patients themselves is already in place at the Office.

Curators

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

In order to ensure compliance with these obligations the Customer Relations Unit sent reminders to all curators appointed after the coming into force of the Act and assisted the majority of curators in familiarising themselves with their reporting obligations. A 'hand-holding' exercise was conducted to ensure that the proper and complete documentation is submitted to this Office and it is envisaged that this exercise will continue indefinitely.

Media Presence and Participation

During 2014 the Commissioner and members of the staff participated in 35 radio programmes and 3 television programmes. These included a regular 90-minute programme once a month on RTK - the Catholic Church radio station, and bi-monthly slots of approximately 15-20 minutes on PBS - the national radio station. During these programmes issues related to persons with mental disorders were discussed, providing an insight into the roles, objectives and functions of this Office. Officers present on these programmes replied to queries made by the public, including live phone-ins, offering advice and guidance in a spirit of advocacy and empowerment.

This Office was also involved in the publication of articles in the local press viz.

- Write-up on *The Benefits of Guardianship in Mental Disorder and Older Age*, Malta Independent on Sunday.
- *Do You Know your ABC of Good Health?*, report by the Times of Malta in connection with the Health Literacy Survey commissioned by this Office.
- *30,000 Maltese Suffer from Chronic Depression,* report by the Malta Independent.

- *30,000 Persuna f'Malta jbatu minn Dipressjoni Kronika,* report on Newsbook.com.mt
- *Disparaging Words should be removed from Criminal Code,* report by Malta Today (1st April 2014).
- *Private Church Run Homes for the Elderly fall behind,* report by Malta Today (1st April 2014).

The office website with new content was launched in January 2014. Throughout the year, the website was updated with information on events and other relevant material, including posting of write-ups on mental health problems and articles to local media and the Journal of the College of Family Doctors. The website can be accessed using the link: http://commissionermhop.gov.mt

Interface with the Judiciary, Police and Service Provider Entities

The Commissioner and the Legal Advisor for this Office were invited to attend and address a Seminar organised by the Judiciary Studies Committee, in which the implications of the Mental Health Act on the judicial system were discussed in detail. Issues discussed included: the appointment of a specialist in Psychiatry to report to the Court in the case of treatment orders issued under the Probation Act; the separation of forensic in-patients who were considered insane at the time of committing the crime or at the time of pleading from inmates from Corradino Correctional Facility who develop a mental disorder that requires in-patient care; the curtailing of abuse of the system by prisoners who are admitted to mental health facilities; the promotion of guardianship instead of interdiction and incapacitation; and the new procedure for the granting and revocation of court orders for persons who were considered insane at the time of committing a crime or at the time of pleading.

A working group between Mental Health Services, the Police and this Office which was established in 2012 was re-constituted following a meeting called by this Office with the Acting Commissioner of Police and Senior Police Officers. Collaboration and cooperation between the Police Force and Mental Health Services is critical to ensure that the person with a mental disorder receives the best possible and safest care. A protocol has been drafted by the Mental Health Services and this Office to

provide clear and practical guidelines to Police and Healthcare professionals on their respective roles and responsibilities when working together to respond to the needs of people with a mental disorder. This draft document will be open for consultation among the stakeholders. Feedback from this consultative process will be incorporated in the final report.

Regular meetings were held between staff members from the Office of the Commissioner and Mental Health Services Management to ensure a smooth transition in the changes required following the coming into force of the Mental Health Act and to identify the best possible ways to co-ordinate the implementation process. The Office assisted Mental Health Services Management to review the drafts of consent forms, the preparation of Schedules and Application Forms in relation to the Mental Health Act, the appointment of responsible carer forms and the Request for Personal Data forms. Regular exchanges of information focused particularly in the first weeks of implementation on the correct use of the new application forms required by the Act.

Several staff officers provided advice to healthcare professionals on issues in relation to the Mental Health Act on an ad-hoc basis. A meeting was held with the top management of the Primary Health Department in order to ensure seamless implementation of the new Act by General Practitioners and staff working in the various health centres. During the reporting period this Office provided Information Sessions concerning the Mental Health Act for healthcare professionals as well as to other professionals or entities who requested them. Information Sessions were held with B.Sc. Mental Health Nursing Students, SEDQA, Probation Services, APPOGG, Malta Federation of Professional Associations, Primary Health Professionals (3 sessions), Civil Society Committee (MCESD), Agenzija Sapport, Gozo General Hospital Professionals, and OASI - Gozo.

Throughout 2014, the Superintendence of Public Health through the Department of Healthcare Standards issued licences for the operation of the Psychiatric Unit at Mater Dei Hospital and the Psychiatric Wards at Gozo General Hospital. The Office of the Commissioner pressed for licensing of these in-patient facilities purporting to provide mental health services, in order to safeguard the rights of persons living in

hospitals. It is desirable that PPP programmes in the community are also provided from adequately licensed premises and facilities. The last step in this process will be the licensing of community based services, which involves service delivery protocols and standards rather than the licensing of premises.

Several other activities undertaken by the Office to monitor the implementation of the Act are covered in more detail in the subsequent section on “Influencing Policy”. This section will also describe the policy changes that the Office will be promoting and advocating in order to safeguard the rights of persons with mental disorder using the backing given to the Commissioner by the legal framework as approved by Parliament.

Influencing Legislation

Mental Capacity Legislation

The need to look at Mental Capacity in the light of current Maltese legislation and what changes are necessary in order to give adequate protection to vulnerable people who lack mental capacity in the absence of mental disorder was the theme of a Reflection Seminar organised by the Office which was held under the auspices of His Excellency the President of Malta Dr George Abela on the 22nd February 2014 at Verdala Palace in Buskett, Rabat.

In his introductory remarks, the President of Malta called for more awareness to an issue which touches the most vulnerable people at the core and urged politicians to look at the necessary legislation which has the people and their protection as its basis. The EU Commissioner for Health and Consumer Rights Dr Tonio Borg stressed that this theme was in line with EU actions and in agreement with the EU paper on Fundamental Rights that in front of the law everyone should be treated equally and not discriminated against. The Speaker of the House of Representatives Dr Anglu Farrugia appealed to professionals working with people who have a temporary or transient problem of Mental Capacity to act in the best interest of the person in the absence of formal protective means in legislation and proposed for consideration the introduction of legislation and/or mechanisms such as Advanced

Directives, lasting powers of attorney practices and assisted decision making. The Minister for Health Dr Godfrey Farrugia explained how health conditions may lead persons to a position where others have to take decisions on their behalf and how sometimes these situations may strip persons of their rights and dignity. He encouraged all professionals dealing with the person to take their time to ensure that the wishes of the person are being taken into account and safeguarded.

In the key note address of this seminar, Chief Justice Emeritus Vincent De Gaetano highlighted the developments in the legal framework from practices in the early 70s where a person's mental capabilities depended upon the final word of the psychiatrist to a more holistic framework which takes into consideration various aspects of the person's life and abilities. He described the words 'mad', 'of insane mind' and in a 'state of madness' as expressions which were built on medical jargon and which had a very negative connotation on a social aspect. He based his detailed and scholarly presentation on 3 main themes: an overview of relevant legislation from Maltese and European laws, an overview of definitions from these laws which were relevant to lead to the following discussion by panel of experts and lastly lessons which can be learnt from the European Court of Human Rights which can help in the local context and scenario.

During the expert panel and floor discussions, the following issues were raised:

- A good quality service includes the right to active participation of the person in the decision making process, the right to free and informed consent, the right to complete and clear information in a format that is understandable by the person concerned, the right to withdraw consent and the right to respect and dignity. There must be special provisions and added protection in case of minors and adults who are unable to give consent.
- The underlying principles of any service are added benefit, the least restrictive option should prevail, the autonomy of the person is to be respected at all times and the vulnerable person is to be legally represented in the decision making process.
- Government policies and bodies must provide protection to people who are unable to make decisions for themselves.

- Empowerment means giving vulnerable persons and persons with disability better control over their lives including their health when they are still well enough to do so in preparation for a time when they might not be capable of doing so. Empowerment can guide vulnerable adults to decide early on what to do if, in the future, they cannot take decisions regarding their estate, their residential requirements and their care and health.
- The impelling importance to have an ad-hoc register accessible to practitioners whereby one can readily verify if a person is interdicted or incapacitated.
- It can be argued that the request of a medical certificate attesting the testamentary capacity of a client, in cases where there could be doubt about this, is tantamount to an admission that the person lacks adequate capacity. Legislation and unequivocal guidance on how to act when faced with such common-place cases is therefore urgently required.
- Concerning substitute and assisted decision making, our legal system needs to incorporate instruments such as 'advanced directives' and 'lasting powers of attorney' in view of the added benefits these instruments would permit to individuals, empowering them to make decisions for future moments in their lives when it will be no longer possible for them to validly posit their consent. It must be remembered that together with advantages, there are problems linked to the use of such instruments and it is appropriate that any debate concerning the introduction of such instruments takes an appropriate amount of reflection, study and thought.
- The concepts of 'consent' and 'capacity' in our law need to be broadened to incorporate consent that is conditional on a set of future contingent circumstances.
- It is strongly advisable to promote the setting up of trusts in accordance with the Trusts and Trustees Act (Chapter 331, Laws of Malta), an available legal instrument, that can offer comprehensive solutions to vulnerable individuals.
- A 'one size fits all' approach is wrong - different acts require a different degree of capacity; different vulnerabilities pose different threats to individuals. It is only by adopting an interdisciplinary approach that the best solutions can be found such that the medical dimension is reflected in a legal system that

safeguards the interests of vulnerable individuals while preserving their sense of dignity.

- Last but not least, all or any of these proposals will precipitate an overhaul of present cultural concepts and a change of approach by the public at large. Informing individuals, families and society of these possibilities is a step forward to breed the cultural change that goes alongside a robust system of protection of vulnerable adults.

The concluding remarks by Chief Justice Emeritus Vincent De Gaetano were focused on the important aspect of human dignity which is not specified in the Convention of the European Rights but is found in the EU Charter of Fundamental Rights. In *Article 1,* the charter states that human dignity is inviolable. It must be respected and protected. This is amplified in *Article 2* concerning the right to life which states that everyone has the right to life and no one shall be condemned to the death penalty, or executed. This enforces the respect for the person from the slightest hint of conception to the last remaining bones of a being. Only with these principles in mind can one open a debate on capacity or incapacity. The general report of the seminar is attached at Appendix 2.

The issue of the independence of the Office of the Commissioner raised by Chief Justice Emeritus Vincent De Gaetano in his keynote address was taken up twice during 2014. The Minister for Justice referred to the role of the Commissioner as independent advisor on criminal cases committed to psychiatric care during question time in Parliament whilst discussing PQ 7903. The Opposition spokesperson on health gave notice of a proposed motion to improve security of tenure of the Commissioner.

Electoral Legislation

Throughout the reporting period, the Office of the Commissioner has continued to positively influence the enactment of further amendments to electoral legislation with the introduction of mixed ballot boxes in all residential homes where more than 50 persons reside on a permanent basis, thus extending and facilitating the democratic process for vulnerable persons to exert their constitutional right to vote without the need to be transported and conveyed to their respective locality polling stations to

cast their vote. This was implemented in the European Parliament (EP) Elections of May 2014 with excellent results in terms of turnout and therefore democratic participation. From the report on the EP 2014 of the Electoral Commission it transpires that turnout on the all hospitals, SVPR and 23 retirement homes compared very favourably with national turnout.

	Eligible Voters	Votes Cast	% Turnout
All Hospitals	1379	957	69.4%
S.V.P.R.	1147	757	66.0%
Residential Homes	2477	2010	81.2%
National	344356	257588	74.8%

Following the EP 2014 elections, further discussions were held between this Office and the Chief Electoral Commissioner concerning voting by vulnerable persons and persons with dementia. This Office proposed further recommendations to continue to improve the actual process through which elderly and vulnerable persons exercise their right to vote. These recommendations are that the Electoral Commission builds upon the experience gained in past elections to draw up, agree upon and introduce written guidelines and Standard Operating Procedures to be followed:

- by all Electoral Commissioners in assessing the fitness of residents to be transferred from their ward/bed/unit to the polling area set up within the institution in order to cast their vote, and
- by all Assistant Electoral Commissioners in all polling stations across the Maltese Islands in dealing with voters who may request assistance or have difficulty to express their voting preference due to dementia or other mental health disorders.

Such documents should be drawn up in conjunction with the clinical expertise of the members of the Medical Board appointed in terms of the Electoral Act and should be made available to the Commission and all Assistant Electoral Commissioners together with other documents that they are currently provided with. These two documents will be extremely helpful in ensuring equitable arrangements throughout

the entire electoral process where vulnerable persons and persons with dementia are concerned.

In the future, this Office would wish to see the introduction of mobile ballot boxes in hospitals, SVPR and retirement homes, thus averting the need to move patients and beds and bringing voting rights to the patient bedside.

Influencing Policy

The Office has made a number of interventions and representations aimed at influencing mental health policy, other national health policies and strategies, and those policies that are in some way related to its mandate which involve other ministries and the World Health Organisation.

Mental Health

Although it is envisaged that the full effect of the changes that emanate from the Mental Health Act, 2012 will be in place in four (4) years' time, it is encouraging that in the first few weeks of full entry into force, a number of changes have already been implemented. The new applications are progressively being better completed and the quality of the information backing requests is improving. Care plans are being submitted, although the completeness and quality of some of the care plans needs to be reviewed. Furthermore evidence of involvement of patients and responsible carers in the care planning process should be better documented if it is indeed happening. Timeframes are being respected and this augurs well for the deeper changes that need to occur and the interesting policy challenges that need to be tackled in the coming months and years.

The major contribution from this Office to the future changes and upcoming challenges is the report of our visitation to the Mental Health Services pursuant to the provisions of Article 6 (1) (k) of the Mental Health Act. The full report of the Visitation for 2014 may be seen at Appendix 3.

The aim of the visitation was to determine that patients are receiving care with dignity and respect and that their rights are being upheld. The aspects of care that were noted included the environment within which the person received care, suitable documentation of the care provided, positive patient experience, privacy, autonomy, communication and social aspects of care. The visitation assessed therefore the level of compliance with the rights of persons with mental disorders and their carers listed in Article 3 of the Mental Health Act. The assessment was based on observations carried out during the 17 planned visits to 46 different care facilities within a limited timeframe and in the presence of ward or unit management staff. Further evidence was collected from information and documentation provided by staff, examination of patient records and private interviews with service providers and users.

As a general rule there was wide variation in the ambience and quality of care but in most cases the basic needs of the patient were satisfied. The leadership skills and dedication of the lead health care professional was the common denominator that determined the quality of service being delivered in the ward, unit or facility.

Observation and discussion with health care providers showed that in general staff in the more acute wards and in the community were more motivated. This was reflected in their enthusiasm and interaction with their clients. However, in most sectors, staff also complained of shortage in human resources especially in the areas of psychology and social work and consultants claimed that these were the main factors barring the formation of multi-disciplinary teams conducive to multi-disciplinary care, as required by the Mental Health Act.

Whilst **no evidence of discrimination** could be elicited, language can be a barrier for foreign patients.

We found **no evidence of abuse of restrictive care**, but as disclosed during patient interviews, ward staff sometimes resort to threatening patients with seclusion in time-out rooms or other punitive measures such as restricting access to main garden and activity centres as a behaviour control measure. Furthermore, ample internal garden

space and walking pathways adjoining hospital wards are poorly kept and largely underutilised and patients are largely confined to the general ward area.

No evidence of cruel, inhuman or degrading treatment could be elicited and protection mechanisms such as incident reporting, seclusion registers and customer care are in place. The introduction of the regular reporting of near-misses should be considered by management and all professionals working with patients should increasingly focus on ensuring that patients are informed about their rights, including their right to lodge complaints and the mechanisms for doing so.

We could witness mutual **respect** between staff and patients. In hospital settings, patients were generally clean and groomed and this is evidence of regular practical assistance by staff. The clothes worn by patients were clean and wearable. It was noted that some patients do not even have any personal belongings, others had belongings in bundles or plastic bags near beds. The lack of a personal cupboard in some wards must be assessed against the real rather than the perceived ability of patients to take care of themselves and their belongings. The lack of partitions between beds in all dormitories should be revisited. As part of the therapeutic engagement process patients should be allowed better choice and control in their everyday personal and care needs. A handful of staff members need to be reminded about the importance of self-grooming and self-respect.

Privacy varies from ward to ward and from case to case and the balance between privacy and risk can be very delicate in certain situations. Visits in private by relatives is possible in some wards whilst more privacy is needed in other wards**.** Full implementation of private visiting facilities should be fairly easy to achieve given the extensive size of most units.

Regarding **service delivery aspects,** the level of cleanliness varied between wards, with some wards needing improvement in cleaning standards. 30-40% of patients lapse Psychiatric OP appointments. On a daily basis up to 25 patients living in the community collect their medication supplies from Mount Carmel Hospital Pharmacy rather than a neighbouring pharmacy through POYC.

Rehabilitation is selective and distant from the ward environment and the level of stimulation and activity on a daily basis at ward level seems to be low (in most cases this consists of a daily bath, and then sit-stare-smoke-watch TV until it is time to either eat or sleep).

On **Community Care Services**, dedication and motivation among staff and appreciation by users were evident where community care is being offered. Community care is over-subscribed and cannot support new urgent referrals by GPs and family doctors. Moreover the service is discriminatory on the basis of residence since no services are available in the South Western, North Inner Harbour and Northern Regions. Crisis intervention team and outreach services are ineffective.

On **Consent Forms**, their use is slowly improving. Evidence shows that some wards and certain staff members fail to appreciate the importance of eliciting and recording informed consent while others view informed consent as merely a paper exercise. More staff education initiatives are needed focusing on the development of a culture for patient information, engagement and empowerment.

On **Multidisciplinary Care**, the multidisciplinary approach is visible and evident on ward rounds with consultants and teams discussing issues in the presence of patients and carers. It is a pity that the formalisation of this approach and process is not appropriately and holistically documented in the patient medical record. Psychologists, social workers and to a lesser extent occupational therapists do make and keep regular detailed notes which are filed separately in their offices and this practice is not conducive to a holistic approach. The introduction of a template for multidisciplinary care plans would facilitate this process.

On the identification of a **Responsible Carer,** records in community services are mostly aligned to this concept. Whilst the new law empowers patients themselves to appoint in writing a responsible carer of their choice, the “next of kin” concept is still ingrained in the mind of staff. The formal appointment of responsible carers needs to improve in hospital settings. Furthermore it was observed that the details of the curator of interdicted / incapacitated patients were not routinely recorded in the medical records. Staff education initiatives need to emphasise the importance and

the role of the responsible carer or curator in patient representation, in the safeguarding of patient rights and in continuity of care.

Pay-phone access is present in all wards and units. This facilitates **communication** of patients with the outside world and patients are helped by staff to use telephone facilities. The use of mobile phones and other personal devices is generally not permitted in wards with some exceptions**.** No efforts should be spared to improve communication, so that patients can remain in contact with their relatives and friends and *au courant* of what is happening around them – this prevents isolation and institutionalisation.

From the patients' perspective, the proposals for improvements in the delivery of mental health services which emante from our report include:

- Wards where social care only is required should be declassified from psychiatric facilities and re-classified as residential accommodation for long term care.
- Patients with general medical and geriatric care needs should benefit from the inputs of specialists in internal medicine and geriatrics as is common practice in other non-psychiatric hospital and residential settings. This may obviate the need to refer such patients to Mater Dei Hospital for specialist care as happens currently.
- Better holistic care through the contribution of all health care professionals, must include the patient and the responsible carer.
- The re-classification of wards into acute, rehabilitation, residential, chronic (geriatric and medical) reflecting different care needs.
- The development of more specialised units (e.g. adult rehabilitation; child and adolescent mental health) on similar lines as has been done for eating disorders.
- More investment in community mental health facilities and preventive mental health.
- More varied interventions aimed at empowering patients to be more autonomous – (e.g. Occupational therapy should focus more on life-skills, job coaching, cooking, computer, home management).

- The building and infrastructure support services in Mount Carmel Hospital and in the mental health wards of Gozo General Hospital need extensive investment for proper refurbishment. The overall ambience of the wards is austere and dated. Some wards are in more urgent need of maintenance for leaking roofs and damp walls; some bathrooms need urgent upgrading. The environment, structure and furnishings of the Psychiatric Unit at Mater Dei Hospital should be the standard for care of psychiatric patients in a hospital setting and the environment, structure and furnishings of the Psychiatric Out Patients' at Mater Dei Hospital should be the standard for care of psychiatric patients in a community setting.
- Better communication between care providers in the hospital setting and in community based services is essential.
- The patient would benefit if care provided by psychiatric teams moves towards subspecialisation as has happened in other clinical areas.
- Acute Psychiatry needs to be developed and Rehabilitation Psychiatry needs to be revamped.
- The ambience within which care is provided in the Forensic Ward for CCF inmates is grossly inappropriate due to overcrowding.
- The ambience within which care is provided in the Asylum Seekers Unit is grossly inappropriate due to segregation in dilapidated single cells with limited possibilities for social interaction and no provision for any activities. Asylum seekers are further isolated due to the lack of cultural mediators.
- Early consultation with a psychiatrist in the Child Guidance Clinic is possible through an urgent referral system but less urgent referrals can take up to two years before being seen by a psychiatrist. This state of affairs is unacceptable and needs to be reviewed immediately.
- The Young People's Unit has been under the focus of this Office since its inception in 2011. The issues of mixed diagnostic categories in the same ward environment persist. The lack of appropriate seclusion facilities remains, so much so that supervised admission of youngsters in adult wards still occurs occasionally. Adolescents with challenging behaviour have the right to adequate aftercare and rehabilitation in the community leading to their social

integration. Our recommendation remains that this is best achieved through specific supervised residential facilities in the community.

- The organisation of patient records needs to be improved - the medical diagnosis and the type of admission of the patient could not be easily retrieved. Regular entries in patient files were logged on acute wards but were relatively sparse and occasionally absent in some rehabilitation wards.
- Eliciting informed consent and involvement of responsible carers are two important patient rights that underpin the Mental Health Act.

It is incumbent upon the management of Mental Health Services to examine the above proposals within budgetary and resource allocation constraints. The ultimate goal is to shift care from restrictive hospital settings to more open supported care in the community. The implementation of these recommendations should empower persons with mental disorders to be more autonomous, to lead a more dignified life and to be productive members of society.

Child and Adolecent Mental Health Services (CAMHS)

The Permanent Committee for Health of the House of Representatives discussed the situation of CAMHS in an ad-hoc session on 8th July 2014. The contribution of this Office to the debate is at Appendix 4. The full debate can be accessed from the Malta Parliament website on http://www.parlament.mt/file.aspx?f=49107

Other Health Policies and Strategies

The Office provided detailed responses from a mental health and public health advocacy perspective on a number of health policies and strategies.

Following comments by this Office, the **National Health Systems Strategy** published in September 2014 now includes extensive references to mental health services and the impact of the Mental Health Act on service development and delivery.

A common feature in most local policy discussions is the lack of appreciation of the mental health aspects of chronic disease and other health issues. Through the intervention and active involvement of the Commissioner and several professionals

within the Office, we are trying to fill this important gap in mental health advocacy. As a result, for example, the **National Strategy for Diabetes 2015-2020** includes substantial references to the mental and psychosocial aspects of care of diabetic patients, their families and carers and acknowledges that emotional health and wellbeing can be affected by coping with diabetes and as a side effect of some medication. It is well known that the prevalence of depression is approximately twice as high in people with diabetes as it is in the general population and locally, people with diabetes are more likely to report symptoms of chronic anxiety or depression when compared to non-diabetics. This is followed through with a series of recommendations on methods of improving the mental health and wellbeing of diabetics. When the **Breastfeeding Policy** was being discussed, this Office emphasised the need to link this policy to monitoring and early detection of perinatal mental health problems particularly, postnatal depression and feelings of "failed motherhood" among women who are unsuccessful in breastfeeding their babies. Concerning the **Food and Nutrition Action Plan,** policies and strategies concerning obesity must take into account the links between food consumption patterns and mental disorders. Furthermore patients suffering from mental disorders gain significant weight when exposed to psychotropic medications. In addition to reducing the patients' willingness to comply with treatment, this weight-gain may create added psychological or physiological problems that need to be considered and addressed.

The above examples demonstrate the commitment of this Office to continue to emphasise the importance of the mental health burden of chronic disease and also the poor outcome of chronic disease in persons with mental health problems. This Office will continue to uphold the age-old concept of the Romans of – *mens sana in corpore sano* – which has been translated by WHO into – *no health without mental health*.

During 2015 the Office will continue to uphold these principles and look further into new areas such as

- mental health and the workplace;
- mental health in cancer patients and their families; and
- the possible links between obstetric history and the mental health of children.

Education Reform

As a part of the National Consultation on the proposed 10-year integrated strategy for education in Malta and Gozo and on consequent amendments to the Education Act (Cap 327 of the Laws of Malta), the feedback from this Office submitted to the Minister for Education included recommendations for the

- early identification of children at risk of developing mental disorder or ill-health,
- early intervention through evidence-based psychosocial and other non-pharmacological intervention,
- continued risk-assessment of the child and the child's immediate family and home environment throughout the school years,
- strengthening of school counselling services,
- strengthening of child and youth development programmes,
- stress prevention & management programmes,
- health promotion, individualised & personalised assessments,
- identifying and addressing child bullies and those being bullied,
- early identification of substance abuse,
- active follow-up of early school leavers and drop-outs,
- teacher training in mental health issues & their management,
- adequate employee support programmes for teachers and other educational staff,
- the promotion of a whole school approach to health,
- response to the needs of migrant children and the effects that such culture mixes may have on local children, and
- the continued investment in life-long education and learning.

Green Paper: A Framework for Poverty Reduction and for Social Inclusion

As part of the national consultation process, feedback from this Office to the Minister for Family and Social Solidarity recommended that measures should represent a sustainable balance between social protection measures and personal empowerment of those most vulnerable namely through investment in health and education.

Income remains one of the most important determinants of poverty and social exclusion, hence the importance of work and measures aimed at addressing mental health issues to ensure that persons with mental disorder are absent from work for the shortest time necessary, retain their skills and abilities, return to the workforce as soon as possible and are followed up to prevent relapse. We also recommended

- the creation of innovative and sustainable employment opportunities for persons with mental disorder, incentives for potential employers, and mechanisms which ensured that persons with known mental disorder are not socially excluded;
- community-based integrated child and adolescent psychiatric services;
- measures aimed at providing support to parents with young children, single parents, and older persons; and
- a revisiting of the various income and social benefits systems.

This Office stresses the need of working together across departments, sectors, ministries, the private sector, the voluntary sector, the Church, and the rest of civic society through the principles of solidarity and social justice.

National Dementia Strategy Malta 2015-2025 Consultation Document

The feedback from this Office included recommendations on the proposed process of strategy formulation and implementation, the clarification of roles, the involvement of other NGOs besides the Malta Dementia Society, the inclusion of a Gozo dimension and a gender dimension, research into published or available local mortality and morbidity data, a better focus on prevention and early onset dementia, a reference to migrants, an updated directory of services for dissemination amongst healthcare professionals and service users, their families and carers, and the preparation of the health and social care workforce through all levels of training on the impact of dementia.

National Policy on the Rights of Persons with Disability

In reviewing the draft National Policy on the rights of persons with Disability, this Office commented on the lack of definition of disability and the absence of any

reference in the policy to (a) disability in older persons, (b) disability in persons with mental disorder, (c) the special needs of persons with a disability who may also have a mental disorder, (d) the mental health needs of persons with a disability, (e) degrees of disability or multiple disabilities, (f) children of parents with disability, and (g) issues related gender as a cross-cutting theme within the policy.

Our recommendations included

- widening the concept of accessibility from ramps and door widths to adequate lighting, sound proofing, and decoration of public places,
- wider availability of information material using large fonts, the use of proper communication terminology,
- extending accessibility to educational facilities to pre-primary, kindergarten, nurseries and child-care centres,
- the provision of career and vocational guidance to children and adolescents with disability throughout secondary and post-secondary school,
- provision of training on disability to all health and social care professionals throughout vocational, undergraduate and postgraduate training,
- sensitising maternity services to mothers who may have just given birth or are pregnant with a child with a disability,
- promotion of independent living,
- addressing capacity legislation and a move from substitute decision making to assisted or shared decision making,
- specially adapted musical instruments, sports and other leisure equipment,
- support to children living with parents with a disability.

Draft National Standards for Residential Care homes for Disabled Persons

Whilst commending the multidisciplinary contributions to the formulation of the draft standards, this Office requested the recognition of the basic right of a person with disability to live with a partner through the inclusion of provisions in residential care homes for couples where one or both partners are persons with disability. We recommended increased emphasis on the need of active integration of care homes and their residents within town or village community, both within management policies and through the involvement of local organisations. These same standards

should apply also to respite beds whether these are within the same residential facility or within ad-hoc respite accommodation. The service provider should be formally obliged to conform to the standards and should inform in writing the residents of the home of their specific rights and duties as residents. This Office is currently participating in the working group set up by the Department of Social Welfare Standards that is preparing the national standards for day care facilities for persons with disability.

National Minimum Standards for Older People Residential Facilities

The principles underpinning this document fostered the provision of a service which was patient centred and upheld the rights of the older person for dignity, privacy, autonomy and physical and mental well being. The standards were well presented and detailed. The only recommendation put forward by this office is the need to have a legislative framework to regulate these standards. The National Minimum Standards suggested that this could be brought about by a Legal Notice. However, this is not possible unless a parent law is in place and from which it can be promulgated. Two options were suggested:

(i) Utilising the Medical and Kindred Professions Ordinance (Chap 31-Laws of Malta) (MKPO). Article 98 of this Act currently regulates homes for older persons.

(ii) Utilising the Health Act, 2013 wherein there are extensive powers granted to the Minister for Health to promulgate regulations for the operation of healthcare providers.

Contribution to the National Youth Policy framework

Aġenzija Żgħażagħ is devising the youth policy for the years 2015 – 2020 on behalf of the Ministry of Education. A joint meeting was held to identify common issues of interest. Mental disorders in early life can threaten the development of individual social, educational and vocational skills, which skills are indispensable for entry into the job market and eventually to be a financially independent adult. The burden of mental illness may have life-long consequences not only at an individual level but also on the family supporting the person with mental disorder and ultimately the national economy. Adequate investment in the mental health of adolescents would translate into multiple returns for the individual and society. The unique development

needs of adolescence and the complexity of mental disorders necessitate the adoption of an integrated inter-sectoral approach through the setting up of a dedicated and specialised adolescent and young adult unit made up of representatives from the health, social and education sectors.

A three-tier approach is to be adopted:

1. Cross sectional action for mental well-being aimed at all adolescents through:
    a. Promotion of healthy lifestyles and prevention of mental disorders; and
    b. Empowerment through teaching adolescents how to be assertive

2. Early detection and early referral of adolescents with mental health problems through :
    a. Training of individuals and professionals working with adolescents; and
    b. The introduction of specific screening tests either by the school health or psychology services or in the community by family physicians or other health care professionals.
3. Targeted programmes for adolescents at highest risk, including adolescents with challenging behaviours, adolescents from deprived and problematic social backgrounds, looked-after youngsters and unaccompanied migrants through:
    a. The development of specific interventions to empower and support these individuals and their families; and
    b. Personalised counselling and coaching through adolescence and early adult life by specifically trained individuals.
    c. Adequate care facilities within the community where adolescents can receive care during acute periods of crises.

The Commissioner and senior members of the staff accompanied a delegation from Aġenzija Żgħażagħ during a visit to YPU and other locations where young patients with mental disorders are normally treated. The visit was followed by a meeting with MHS management.

A Positive Parenting Policy for Malta – 2014-2018

This document has a very solid theoretical background backed by extensive literature research. It represents a concentration of local social research which

however at times lacks logical sequence and furthermore not all research quoted is relevant. The document lacks an EU and Council of Europe perspective where there is extensive work and action that has already been implemented. Parents are not always a male/female couple. There is a scanty reference to teenage parents when it is well known that these pose major problems. The main weakness of this document is where it comes to translate literature and theory into action. The area of action lacks focus and adopts a piecemeal approach. There is a confused approach to stratification of risk and hence the identification of risk groups.

It was therefore recommended that the document be revised to present the proposed implementation task force with the targets, prioritisation and timeframes within which action is expected. In order to maximise available and finite resources, the policy should evaluate and identify the vulnerable as evidenced through available research and advocate a strategy that adopts a two-rail approach: normal and at risk. Actions therefore need to be constant and ongoing opportunities that identify risk and be sufficiently focused and flexible to deal with those at risk on a more specific basis. The Office was informed that it will be further consulted prior to the finalisation of the policy.

World Health Organisation

In March this Office provided feedback on two policy documents referred to it as part of the WHO political consultation. These documents were:

- Draft Strategy for child and adolescent health and development in the WHO European Region 2014 – 2025: Investing in Children and adolescents – better health throughout life.
- Child Maltreatment prevention action plan 2014 – 2020.

The general recommendations included that:

- the overall aspiration stated in these documents is extended to the unborn child from the moment of conception,
- access to age and gender appropriate health and sexuality information should also be culturally and religious-belief appropriate,
- inadequate parenting skills should be targeted as a focus for action,

- strategies adopted cannot be built on a “one size fits all” approach – we need to adopt outreach strategies to enable us to reach out to the most disadvantaged children and adolescents.

With respect to targets and outcomes for tackling depression and other mental disorders our recommendations included proposals for:

- early identification of children at increased risk of developing mental disorder or mental ill-health,
- early intervention through evidence-based psychological and other non-pharmacologic interventions,
- continued risk assessment and follow-up of the child and the child’s immediate family and living environment,
- strengthening school counselling services,
- child and youth development programmes,
- age-appropriate stress prevention and stress management programmes,
- early identification and targeted action on bullying and substance abuse,
- focus on low educational achievers,
- active follow-up of early school leavers,
- appropriate training of educators,
- ensuring an adequate data set for monitoring child and adolescent mental health,
- monitoring the number of psychiatric hospital admissions and use of mental health services,
- reducing the number of school drop-outs, and
- targeting the mental and psychological health of migrant children whilst giving due attention to the mental health and psychological needs of local children exposed to this phenomenon.

Investigation of complaints

Allegations of breach of human rights

In 2014 this Office received and handled twenty four (24) cases of alleged breaches of human rights that included, inter alia,

- unlawful detention in mental institutions,
- abusive behaviour and treatment (by formal and informal carers),
- harassment and
- issues relating to the care and treatment of migrants.

In each case, the Office listens to the complainant or reviews the complaint or allegation and undertakes any necessary investigation as appropriate. In cases where there appears to be a *prima facie* solution to the complaint, this Office communicates its recommendations for said solution to the entity concerned and follows up with the complainant to ensure a satisfactory outcome.

Cases of a sensitive nature, particularly those of a legal or civil nature, are first discussed internally at senior level and then followed by meetings with the individuals concerned and / or their relatives, where they are offered advice as to how to proceed to seek assistance depending on the nature of the case under review. All other cases were invariably referred to the management of the entities concerned for their views and comments prior to a decision being taken internally on the way forward.

There were no cases which needed reporting any healthcare professional for breach of human rights.

Customer Relations Unit

The coming into force of the Mental Health Act precipitated a constant stream of requests for information and advice from inpatients at Mount Carmel Hospital, their responsible carers and healthcare professionals. Such requests are invariably handled by the Customer Relations unit through telephone and email communications with some cases requiring face to face meetings.

In 2014, the majority of cases were requests for information/clarification concerning real or perceived differences between the repealed Act (Cap 262) and the new Mental Health Act (Cap 525). Other queries related to appeals submitted to the

(defunct) Mental Health Tribunal, the role of the responsible carer and new avenues of redress offered by the 2012 Act.

The Customer Care Unit within the Office also receives calls on a number of issues that do not form part of the remit of the Commissioner. It has been and will continue to be the policy of this Office to listen to and assist whoever requests help – albeit on issues that are best handled by other entities. These requests for assistance occupy a considerable amount of human resource but are considered as a 'hands on' method of educating and empowering our client base. In fact, once representation on behalf of a caller to the appropriate entity or its customer care unit is established, said caller is encouraged to follow up his/her case in conjunction with this Office.

It is once again stressed that customer care units at service delivery entity level must be strengthened in order to respond more effectively and appropriately to client requests and complaints. Referral to this Office should be the last resort and for serious cases where the index of suspicion of breach of human rights is considerably high. Extensive organisational revision of customer care units in public health care services needs to be undertaken in view of the introduction in October 2015 of the Charter of Patient Rights and Responsibilities as provided by the Health Act.

Board of Inquiry – TV use in a Mount Carmel Hospital ward

On the 22nd May 2014, the Commissioner appointed a Board of Inquiry to investigate an incident in which it had been alleged that an inpatient at Mount Carmel Hospital had been beaten up and ill-treated as a result of requesting that a ward television set be turned off a particular political channel.

The Board interviewed a total of 18 persons over 4 sittings. Persons interviewed included the patient, staff alleged to have been involved in the incident, other caring staff, including the patient's psychiatrist and social worker, as well as hospital management. The Board also carried out a visit on the site of the alleged incident and examined all relevant documentation.

In its conclusions, the Board considered the allegation that the ward television set was on a particular political channel as credible and probable. Whilst allegations of a

beating or use of excessive force to control the patient were not corroborated, a degree of taunting which could have contributed to the escalation of the incident was not excluded. The Board also established a number of irregularities concerned with the administration of an unauthorised depot injection to control the patient.

The Board recommended (a) the drafting and dissemination of written guidelines to govern the practice of television use in wards, particularly concerning political programmes, (b) regular staff training in subjects such as emotional intelligence, communication skills, and de-escalation techniques (as relevant), (c) such training should not be on a voluntary basis for staff members who are likely to be faced with such situations, and (d) further investigation and action by the competent authorities into the irregularities concerning the administration of an unauthorised depot injection to control the patient.

Since the alleged incident had been reported in the local media, the Office of the Commissioner issued a press statement which released the main conclusions reached by the Board and its recommendations. The press statement is reproduced at Appendix 5.

Other complaints

A psychiatric community service user requested whether a user could be offered a choice regarding site of injection of a particular depot injection. The Office advised Mental Health Services to consider offering users a choice of injection site whenever the relevant Summary of Product Characteristics of the medication indicated that such a choice was safe and possible. This recommendation was implemented as part of the overhaul of the Antipsychotic Depot Administration policy and charts as a follow-up of the recommendations of the Board of Inquiry mentioned in the previous section.

Visits, investigations and audits

The Commissioner and other senior members of the staff carried out a number of activities to ensure that the dignity and rights of the patients are being upheld and to

identify ways how to work together with other entities in the interests of persons suffering from mental disorders.

Key Performance Indicators (KPIs) for Mental Health

As part of the national Health Systems Performance Assessment, a framework incorporating all the main performance indicators linked to the various vertical health related strategies for Malta was in the process of being formulated in 2014. This office was asked to supply Key Performance Indicators (KPIs) in the realm of Mental Health. The monitoring of KPIs is in line with the mission of this office to promote and protect the rights and interests of persons with mental disorders and their carers through improvement of the standards of care.

Literature research followed by internal discussion, lead to the drawing up of a list of indicators related to mental health settings. A pilot study was performed on the main acute ward - Mixed Admission Ward at Mount Carmel Hospital and the two KPIs were assessed: (a) Evidence of arrangements to ensure safety, privacy and dignity; and (b) Appropriate documentation of patient medical records.

The findings and recommendations are being compiled in a report that will be discussed with Mental Health Services in an attempt to improve the care being offered. This Office will continue to offer its expertise in the area of KPIs with facilitation of their implementation and rolling out to other wards and mental health facilities and their continued monitoring. This would certainly provide the necessary tools for a positive patient experience and improved standards of care.

Incident Reporting

The newly enacted Mental Health Act in Article 6 (g) tasks the Commissioner for Mental Health to review all incident reports received from licensed mental health facilities. As from 10th October 2013 therefore, incident reporting is a requirement by law. Although, incident reporting prior to this date did take place the format was not standardised and unfortunately no statistics or analysis of incident reports are available.

The Office of the Commissioner in collaboration with the Mental Health Services worked to increase the number and quality of reporting. To this effect a short document was compiled outlining the benefits of having a blame free reporting system, providing guidelines on how incident reporting was to be affected and how to improve quality of reporting. The report contained a template to be used when reporting incidents. The template was structured to ensure that all the important points related to any particular incident are captured. The template also allows areas for narrative description of events which may be useful when analysing the event. Events were classified into four categories namely: (i) patient protection events, (ii) care management events, (iii) environmental events and (iv) events to be reported to police authorities.

The new incident reporting format was introduced in the main Mental Healthcare facility and in the psychiatric ward at Mater Dei Hospital on the 1st January 2014. All healthcare professionals and workers were encouraged to report incidents and near-misses. Patients and their relatives or carers can also report incidents. Reports were to be submitted using the agreed template to the Office of the Commissioner. Analyses of all incident reports would lead to the creation of guidelines and protocols with the aim of enhancing patient safety. A total of seventy four (74) incident reports which involved eighty nine (89) service users were submitted to the Office of the Commissioner during 2014.

Social Security beneficiaries at Mount Carmel Hospital

The Office held a concluding meeting with the Department of Social Security concerning its investigation of the system whereby Social Security benefits are transferred to eligible beneficiaries who are patients at Mount Carmel Hospital. A substantial number of eligible beneficiaries receive their benefits directly at the Almoner's office at Mount Carmel Hospital and these pose no issue in terms of the traceability of receipt of benefits.

Our concern remains with regards to two subgroups of beneficiaries: (a) those that receive their benefits directly but subsequently deposit it in whole or in part at the Almoner's office; and (b) those who receive their benefits directly. In these two

situations, benefits either go directly to the beneficiary or else they are directly received by an administrator appointed by the beneficiary.

Based on evidence from Mental Health Services, we have established that certain administrators are not providing sufficient funds to beneficiaries for their daily needs. The joint decision adopted with the Department of Social Security was that such administrators will be investigated by the Department of Social Security on a case by case basis. Mental Health Services are to report such cases directly to the relevant Director within the Department of Social Security, and concurrently commence action to appoint a curator or guardian in accordance with legislation.

Benefit Fraud Investigation – Task Force

The findings of this investigation formed the basis of evidence given by the Commissioner to the Benefit Fraud Investigation – Task Force instituted by the Ministry for Finance.

The current practice adopted within the Department of Social Security (DSS) for the appointment of an Administrator entrusted with acting on behalf of persons with mental or other disabilities needs to be revised. There is no scrutiny on the manner in which benefits are administered by the administrators and the current policy is that, once appointed, administrators cannot be removed.

The current administrative DSS procedure for the appointment of Administrators leaves a lot to be desired. Whereas beneficiaries are, and rightly so, free to appoint anyone to act on their behalf by means of a power of attorney, the DSS has a separate procedure whereby persons assessed as having a mental or other disability (or persons under the age of 18) can be declared incapable of managing their own affairs and concurrently a 3rd person is declared to be the appropriate person to act as their Administrator. All three such declarations (with the sole exception of cases where the benefit being received is a disability pension) can currently be made by one person, namely a priest, a medical doctor/consultant, a university graduate, an MP, a bank manager, a public servant not below the grade of principal or a police officer not below the rank of Inspector. Assessing persons' capacity to manage their own affairs, declaring them unable to do so and declaring who can act in their best

interest are not decisions that cannot be taken lightly, especially in view of the fact that social benefits are, in the majority of cases, the only source of income.

Whereas a number of inpatients at Mount Carmel Hospital (MCH) have been classified as social cases in need of residential care only and therefore making their contributions in terms of LN 259 of 2004, other inpatients in exactly the same position are not being so assessed. This potentially discriminatory situation needs to be addressed.

It has been brought to our attention that persons registered as inpatients at MCH are eligible for social assistance. This social benefit is lost when patients are discharged back to the community. This system creates undue pressure on consultants not to discharge patients but to retain them 'on leave' thereby artificially inflating the actual number of patients at MCH and creating a negative incentive towards re-integration in the community.

This Office recommended that:

- The concept of 'Guardianship' provides a regulated manner whereby a major is (i) declared to be incapable of taking care of his own affairs and (ii) a guardian is appointed. Guardians have reporting responsibilities and therefore accountable for their performance on behalf of vulnerable persons. It is recommended that administrators appointed through the current DSS procedure are gradually replaced by guardians.
- In the intervening period, where it is alleged that administrators are not providing sufficient funds to the beneficiaries, the DSS should undertake a pro-active role in determining whether this is the case and, if in the affirmative, consider removing the administrator and transferring benefits to the Almoner's office at MCH.
- All inpatients at MCH who only require residential care should start contributing towards their stay in terms of LN 259 of 2004.
- Persons who have undergone inpatient treatment at MCH and who now require treatment either in the community or as outpatients should be

supported through appropriate social benefits. Social benefits should not be an incentive for hospitalisation.

Published lists of incapacitated and interdicted persons

During 2014 the Office continued to follow up the process of reviewing and monitoring the lists of persons incapacitated and interdicted due to mental disorders published in the Government Gazette at the beginning of 2014 by the Courts of Malta and Gozo.

The list published by the Gozo Court in January 2013 was reduced from 116 interdicted or incapacited persons to 64 persons in March 2014. All persons on the list had an ID Number or other details through which they could be identified.

In the Malta list there were 635 persons, of whom 57 persons had no ID Number or any other details through which they could be identified and another 103 persons did not have a registered address on the Common Database. This Office carried out a thorough exercise to try to establish the status of these 160 persons by making enquiries with the Court administration, the Public Registry, Department of Social Security and Department of Health Information. These attempts did not bear any positive results and it is possible that the majority of these persons are deceased, notwithstanding that they still appear on the list of incapacitated or interdicted persons. In May 2014, the Office requested the pertinent authorities to intervene with the Court administration to tidy up the list to reflect the actual situation. This Office was informed that due consideration was being given to set up a working group to work on this matter and to ensure that the necessary amendments are carried out. There has been no further feedback at the time of reporting.

Following representations by this Office, the Court administrtion started forwarding details of new cases of persons who are interdicted and / or incapacitated, together with details of their respective curators. This information is crucial for this Office in order to monitor any person duly certified as lacking mental capacity and is under curatorship according to the provisions of Article 6(1)(e) of the Mental Health Act 2012. Moroever all persons appointed as Curators by the Civil Court are now being

informed of their obligations in accordance with the provisions of the Mental Health Act.

Dar tal-Providenza, Siġġiewi

During a visit to Dar tal-Providenza in Siġġiewi, a number of issues were discussed with a view to improving the mental health of residents. This Office notes and commends the good practices in the storage and administration of medications to residents as well as the incident reporting system adopted by management and staff. There were four specific requests for intervention by the Commissioner and all had been satisfactorily addressed by the end of the year. These were: the planned, regular visit of a Consultant Psychiatrist, the inclusion of staff in training opportunities offered by Government entities, the integration of a service user from Mount Carmel Hospital in the daily activities at the Herbarium and clearer guidelines on administration of medication by carers.

Working in Partnerships

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

Meetings

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

- Stakeholders meeting with Mental Health Services, Ministry for Home Affairs, AWAS, Detention Services, Police, Army convened by the Commissioner and AWAS to raise awareness to mental health needs of asylum seekers (7th February 2014).
- Meeting with the Chief Justice in February 2014. During this meeting it was established that there are a number of common issues that required careful

reflection including the concept of “insanity” in the Criminal Code which differs from the concept of “lack of mental capacity due to mental disorder” in Civil legislation; the issue of removal of disparaging words in the Criminal Code such as Article 339 (1) (n) which still refers to “nies boloh, xjuħ, magħtubin, mifluġin, jew immankati”; the gradual move towards guardianship instead of the more restrictive incapacitation and interdiction. Chief Justice extended an invitation to this Office to attend a Seminar with the Judiciary to discuss the impact of the Mental Health Act on the Courts of Justice. The Seminar took place on 26th September 2014.

- Director Primary Health Care and the acting Clinical Chairperson on issues relevant to General Practitioners in relation to the implementation of the Mental Health Act (24th March 2014).
- Meetings with Hon Chris Fearne, Parliamentary Secretary for Health related to the implementation of the Mental Health Act.
- HOPE participants on the theme of Quality of Care (15th May 2014).
- Minister for the Family and Social Solidarity, Hon Michael Farrugia (2nd June 2014). During this meeting, the Commissioner presented an overview of the most recent contributions of the Office to policies and matters relevant to his portfolio. Copies of the documents were also sent to the Parliamentary Secretary for Rights of People with Disability and Active Ageing, Hon Justyne Caruana for her perusal and necessary follow-up.
- Meeting with Registrar, Guardianship Board (2nd July 2014).
- Meeting with officials from the Administration, Courts of Justice regarding the shortcomings in the list of persons who are interdicted or incapacitated by a Court Decree (29th July 2014).
- Meeting with the President of the Republic, Marie Louise Coleiro Preca (29th July 2014). At this meeting, the Commissioner presented an overview of the position of the Office on several issues of common interest. These included: (1) the establishment of the Office of the Public Guardian as a watchdog authority to oversee care orders, tutorship, curatorship, guardianship, administrators of benefits and support decisions of professional staff; (2) the mental health needs of children, adolescents and youths; (3) mainstreaming mental health, within and outside health care settings; (4) the new Mental

Health Act as a catalyst for change; and (5) the need for further research in mental health and well-being.

- Meeting with the Diabetes Strategy Focus Group at Seminar Room, Mater Dei Hospital (5th August 2014).
- Ex-Secretary and one ex-member of the Mental Health Review Tribunal concerning pending cases following dissolution of the Tribunal and the sudden demise of its Chairperson (4th December 2014).
- Meeting with the CEO of the Foundation for Social Welfare Services (22nd December 2014).

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

- Commission for Pastoral Care for Health Caregivers regarding parish nurses (14th January 2014).
- Richmond Foundation Roundtable Discussion on the proposed licensing of residential facilities which cater for the long term care of persons with mental disorders (18th February 2014).
- The Chair Mental Health Review Tribunal to discuss the handover of any unresolved ending cases to this Office and the joint presentation at the forthcoming visit of the U.N. Sub Committee on Prevention of Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (SPT) (3rd October 2014).
- The SPT (8th October 2014). During this meeting the Commissioner delivered a presentation on the Mental Health Act, highlighting the functions of this Office and the changes from the old Mental Health Act. SPT's reaction was that the Mental Health Act is an interesting model and whose evolution and implementation will be observed with interest.
- Meeting with the Ombudsman (11th November 2014). At the meeting areas of common interest and co-operation were discussed. The Commissioner emphasised the need and the importance of Commissioners with special focus of interest in order to ensure a stronger voice for the vulnerable (e.g. Children, Persons with Mental Disorders, Disabled Persons, Elderly).
- Mr J. Farrugia, Director General Malta Employers' Association on mental health at the workplace (27th November 2014).

Working together on Specific Actions

Business solutions: any gains for Mental Health?

This was the title of a Conference organised by the Office on the 10th June, 2014 at Le Meridien Hotel and Spa in St Julians'. The aim of the conference was to bring together experts from both the business and mental health sectors to share ideas of how to provide person-centred care. Input from the business sector exposes the public sector to the perceived more innovative and efficient operations of the private sector. The full report of the Conference is at Appendix 6.

The coming into force of the Mental Health Act has increased awareness among professionals working in the field of mental health of the need for change to better conform to the provisions of the new legislative framework. The new mental health act is a vehicle for change for mental health services, a tool which can transform the challenges for better care into opportunities.

It is in this spirit that four pillars emanating from the mental health act were identified for further and wider discussion during this conference, namely (i) rights of users and their carers, (ii) patient-centred care, (iii) multidisciplinary collaboration, and (iv) patient safety and quality of care. These topics represent the core values of the act. Healthcare outcomes will only improve if the rights of the service users are respected, if care is patient-centred, safe and of good quality and offered through a multidisciplinary approach. These objectives can only be attained if the right drivers for change are in place namely good leadership, the fostering of trust and collaboration and communication between all the stakeholders, including patients and their carers.

In general the private sector is viewed as being more responsive to embrace change. Businesses are fully aware that it is only through the continuous renovation and reinvention of their product that they may remain valid contenders in a highly competitive market. The ability, knowledge and expertise of the business sector to bring about change were tapped into. Parallels were drawn between the private sector and the four main areas identified from the Mental Health Act. To this end, the head of MEUSAC, compared the rights of the EU citizen with the rights of patients

and their carers; a senior manager Price Waterhouse Coopers Malta, discussed multidisciplinary collaboration; a tourism consultant spoke about the person-centred approach to service provision; and a business management consultant explored the evolution of safety and quality in industry. The mental health perspective on the four pillars chosen was delivered by the Commissioner. In his short opening address the Parliamentary Secretary for Health stressed the importance of involving all the stakeholders, especially the patients' families in order to provide an integrated, good quality health care. He acknowledged the need of a service which is timely and responsive to the needs of the client.

Eight workshops followed. Each workshop was made up of a mix of management personnel and healthcare professionals to encourage discussion between the managerial and operational arms of the mental health service. Each workshop presented a set of proposals stemming from the discussion with the aim to inform policy or practice within mental health services.

The underpinning recommendations that emerged from most workshops included good leadership and common goals, good communication between all stakeholders, workforce that has the required number of employees with the right skill mix, continued training and support of staff and more empowered patients and carers through better information about their rights and available services.

Health Literacy

Following recommendations by representatives from the University of Maastricht in 2013, the Office of the Commissioner in partnership with the National Statistics Authority commissioned a study with the aim of measuring the health literacy level of the Maltese population. The measuring instrument that was adopted consisted of a questionnaire that was constructed by the EU-HLS Consortium and used to measure the level of Health Literacy in eight European Member States in 2011.

The fieldwork for the study was conducted in July and August 2014. This study report is being finalised and the results will be disseminated by the Office in the coming year.

Besides, providing the Office with a profile of the Maltese Population in terms of health literacy levels for areas related to health care, health promotion and disease prevention, the results will also be comparable to those of other European Member states. It will also enable us to identify vulnerable groups within the population with high risk of low health literacy level and explore ways on how these risks can be mitigated. This study is just the beginning of work in this area. It is strongly believed that further work and analysis will produce interesting results that can influence the direction of future policy in this area that is strongly emerging from the margins to the mainstream of European and international debates on health.

Mental Well-Being Think Tank

The Office of the Commissioner for Mental Health with its commitment to promote and protect the mental health and well-being of the population of the Maltese Islands, brought together various experts in the field of mental health and well-being who met on a regular basis and discussed and debated amongst themselves on the best way forward such that it is ensured that our country makes the most of all our resources – both mental and material. The high level team included representatives from the Office, the University of Malta and Mental Health Services.

First, the group undertook a search for abstracts of PhD's and MSc's on mental health research but did not come up with any useful relevant local research. This meant that there were many possible areas and gaps which could be addressed. In order to help the group identify relevant areas for possible further research, external advice on the possible use of Foresight Methodology was sought. Following this, we conducted a modified Delphi approach to identify and agree upon three (3) priority target groups for research, namely:

- Unaccompanied asylum seekers under the age of twenty-three (23) years
- Family survivors of an incident case of suicide or tragic death
- Long term unemployed persons

Following further reflection and discussions and drawing upon inspiration from the UK's Foresight Project on Mental capital and Well-being, the Office proposed to set up a Mental Health and Wellbeing Research Trust Fund together with the Research,

Innovation and Development Trust of the University of Malta and other stakeholders to enable ongoing high quality research in the identified priority areas of mental health and wellbeing (other areas to be considered at a later stage) that would provide guidance to policy makers and translate into wider actions that address both current as well as future challenges within the health sector and the wider society. A detailed research proposal was drawn up and presented to the Ministry for Energy and Health for funding. However, no funds have been provided in the budgetary allocation for 2015. Throughout the coming year, the Office intends to explore avenues of possible partnerships that can support and fund this research initiative.

Working with the Ministry responsible for Health

Implementation of the Convention on the Rights of Persons with Disability

The Office reviewed the Malta Report on the Implementation of the Convention on the Rights of Persons with Disability from a rights' perspective in relation to persons with mental disorders. The document needed to reflect the fact that whilst not all persons with mental disorder met the definition of "disability", there will always be some persons with mental disorder who fell in this category and whose needs will need to be taken into consideration. We also pointed out a number of errors of interpretation with respect to the Mental Health Act and incorrect terminology.

National Standards on the use of Medicines

The Department of Health Care Standards and the Superintendence of Public Health was informed by this Office that during visits to various care facilities questions had arisen as to whether carers can distribute medicines to residents in residential care settings. This matter is included in the Draft National Standards for the Use of Medicine wherein the models for the use of medicines in different health care settings are discussed. It was recommended that the draft should also be aligned to the requirements of the Mental Health Act.

National Standards for Least Use of Restraints

The Department of Health Care Standards and the Superintendence of Public Health presented to this Office the first Draft of the National Standards on least use of restraint, asking for feedback prior to the launch of the consultation phase. We

observed that the document largely dealt with the use of restraint to protect a person receiving medical and/or social care from sustaining greater physical harm. We felt that the document did not sufficiently tackle the situations arising largely within mental health settings wherein the receivers of care may exhibit either deliberate self-harm of a severe nature or violent, aggressive and/or abusive behaviour towards third parties. We recommended that the mental health service providers should be involved prior to the launch of the consultation. It was recommended that draft should also be aligned to the specific requirements of the Mental Health Act concerning restraint.

Selection Board

A senior member of the staff within the Office was appointed Chairperson of the PSC Board entrusted with the selection of the Professional Lead Allied Health Practitioner in each of the following professional areas: Dental Hygiene, Dental Technology, Medical Laboratory Technology/Science, Occupational Therapy, Occupational Therapy, Orthoptics, Physiotherapy, Podiatry, Radiography Diagnostic, Radiography Therapeutic, and Speech and Language Pathology.

Participation in Conferences, Seminars, Workshops & other Events

The Commissioner and senior members of the staff delivered presentations and participated in a number of conferences, seminars, workshops and other events both locally and internationally. These events are excellent opportunities for networking and disseminating the messages linked to the mandate of the Office.

Participation in Local Events

Members of the staff delivered presentations during the following conferences:

- A Wind Rose for Mental Health – keynote presentation in the Conference organised by the Office entitled Business solutions: any gains for Mental Health? Le Meridien, St. Julians' (10th June 2014).
- The Mental Health Act 2012, from Law to Practice for Professionals – CPD lecture for the Malta Federation of Professional Associations (15th May 2014)

- The Mental Health Rights Perspective - Conference organised by the Agency for the Welfare and Asylum Seekers at Corinthia San Ġorġ, St. Julians' (18th June 2014).
- Rights of the Elderly in Old People's Homes - Presentation to healthcare workers working at Sagra Familja Old People's Home, Naxxar (27th June 2014).
- Volunteurope Conference - Excelsior Hotel, Floriana (12-14th November 2014).
- Care in Captivity? - Organised by Jesuit Refugee Services (16th December 2014).

The events, seminars and conferences organised by various Government entities and NGOs in which staff participated included:

- Seminar on Community and Child and Adolescent Mental Health Services at the Dolmen Hotel, Qawra. (9th January 2014).
- Conference entitled *Kura b'wiċċ uman: bi mħabba nħaddnu l-valuri*, organised by the Commission for Health Care Givers Pastoral Care at Mater Dei Hospital Faculty of Sciences Auditorium (4th February 2014).
- Consultation seminar to launch the draft Food and Nutrion Policy and Action Plan for Malta 2014-2020 (20th February 2014).
- Consultation seminar: A National Health Systems Strategy for Malta 2014-2020 (21st February 2014).
- Challenging Behaviour Seminar organised by Speech Language Department (25th February 2014).
- Ir-Realtà tax-Xogħol fit-tagħlim ta' Papa Franġisku – discussion around work and the vulnerable groups, held at Archbishop's Curia (28th February 2014).
- Consultation by Forum Nazzjonali Familja with the theme Familja Istituzzjonijiet (4th March 2014).
- The effective healthcare epidemiologist – Keynote Lecture - 14th Congress of the International Federation of Infection Control (12th March 2014).
- Launch of PROGRESS programme entitled Forms of Violence in Malta – a gender perspective – National Commission for the Promotion of Equality (14th April 2014).

- Decision-making in Hospitals: Processes, Innovative Devices and People – Faculty of Health Sciences (22nd May 2014).
- Public consultation process on the 2014-2020 operational programmes to be financed by the structural funds and the cohesion fund - MEUSAC (29th May 2014).
- The Development and Implementation of a Health Systems Performance Assessment Framework in Malta - why go through the trouble? held at Rehabilitation Hospital Karen Grech (17th June 2014).
- Civil Society Committee at MCESD (17th June 2014).
- Launching of the President's Foundation for the Wellbeing of Society – The Palace, Valletta (25th June 2014).
- OT Conference entitled 'L-Ikel: Bżonn, Pjaċir jew Problema?' held at Dolmen Hotel, Qawra (18th July 2014).
- The National Breastfeeding Policy 2015-2020 at the Phoenicia Hotel, Floriana (29th August 2014).
- 1st National Workshop on Mental Health Promotion and Prevention in Schools at MCH Training Centre as part of the EC Joint Action on Mental Health and Wellbeing. (5th September 2014).
- Seminar - Mental Health Act Implementation organised by Mental Health Services Management at the Hotel Excelsior, Floriana (18th September 2014).
- A Seminar with the Judiciary led by Chief Justice (26th September 2014).
- Ħajja Bl-Iskiżofrenija - Mount Carmel Hospital (10th October 2014).
- Children with ~~Challenging~~ Meaningful Behaviour organised by Richmond Foundation - Dolmen Resort Hotel (17th October 2014).
- Gozo Mental Association Conference – L-istress - Tirbħu jew Jirbaħlek (31st October 2014)
- Volunteurope Conference - Excelsior Hotel, Floriana (12th – 14th November 2014).
- Diabetes - A National Public Health Priority - Mediterranean Conference Centre, Valletta (14th November 2014).
- Health Mind for Healthy Business organised by Richmond Foundation - Victoria Hotel, Sliema (19th November 2014).
- Mental Health Act Seminar for LLB 1 Students (3rd December 2014).

- 'Bridging the Gap' – skills conference organised by EUPA (4th December 2014).
- Launch of the Food and Nutrition Policy and Action Plan, organised by the Directorate for Health Promotion and Disease Prevention - Mediterranean Conference Centre (16th December 2014).
- Mental Health Act Seminar by Magistrate Consuelo Scerri Herrera, organised by Dr Mark Xuereb, Specialist in Psychiatry at the Cavelieri Hotel, St Julian's (19th December 2014).

Participation in Overseas Conferences

International conferences offer an opportunity to share experiences, views and strategies concerning persons with mental problems and older persons and to keep in line with the visions and developments in addressing challenges of innovation at EU and international level. During 2014 the Commissioner and other members of the staff participated in overseas conferences viz.:

InterQuality: International Research on Financing Quality in Healthcare – Project Final Conference, Brussels, 24th April 2014

This was the project closing conference where presentations were made about how the project evolved, representatives of the different work packages presented their outcome on the question of how healthcare systems in Europe are financed, what are their strengths and weaknesses. The audience agreed that there are positive and negative aspects in each system but they can learn from each other and the secret of success is how the necessary reforms are implemented and communicated to the public by the governments. It was interesting hearing the evaluations and a great learning experience at how different governments meet their public's needs within the financial limitations the economic crisis has put in the sector.

IMI-JDRF Patient Diabetes Focus Meeting, Brussels, 24th May 2014

The Innovative Medicines Initiative (IMI) aims to speed the development of better and safer medicines for patients. The event focused on giving the voice to patients' and considering their involvement as crucial to ensure that the focus of the research agenda is on areas of high societal need. The main speakers throughout the day

were patients who shared how they lived with diabetes, what they have achieved despite the difficulties the condition can put on their life styles and how real success relies upon incorporating patients' priorities and needs into the research agenda. Seeing the courage and achievement of many youngsters with diabetes emphasises the importance of persons and their needs abilities rather than their condition.

Society for the Impact of Pain Meeting, Brussels, 2nd October 2014

The sector of Chronic Pain is very vast and effecting a large number of patients around Europe. There are a lot of good initiatives in the sector of pain and these initiatives need to involve stakeholders at all levels from policy makers to service providers, patients and families. There is the need to consider the person as a whole including mental health, social aspect and the importance of person centred care and not having the person fit the services.

High Level Policy Debate on the Critical Role of Caregivers, Brussels, 7th October 2014

Observations on the situation at European level: Caregivers are engaged, and professionals should tap their expertise when providing care. The burden of caring is high, hence the need for respite and education to further empower the caregiver. Caring professionals do not recognise and value the role of family care givers and this often results in fragmented care. The barriers to the delivery of a successful mental health service are compounded by poor political will and insufficient funding.

Conclusions and recommendations:

- Integrating mental health in primary health care;
- Shifting locus of specialist mental health care to community;
- Increasing psychiatric units in general hospitals;
- Strengthening the implementation of Mental Health Strategies;
- Developing the capacity of leaders involved in mental health planning and services;
- Promoting actions to ensure allocation of resources liberated from decreased in patient stays within psychiatric hospitals;
- Involvement of family and care givers;
- Adequate allocation of funds

Driving Mental Health at Work in Europe: Learning from one another, Berlin 29th to 30th October 2014.

This 2 day conference was organised within work package 6: Promoting Mental Health at Work, within the EU Joint Action on Mental Health and Well-Being. Malta is taking part in this Work Package together with ten other European countries. The aim of the conference was to enable a structural exchange of experiences between participating countries, identify challenges, share existing solutions, and improve cross-sectoral co-operation.

Various presentations showed how mental ill-health of workers impacts productivity from sick leave and disability benefits. Mental disorders account for about one-third of retirement disability benefits in the 35-55 year age group. Other presentations showed how mental demands at the workplace impact the workers' mental health state.

In today's world, the human brain is the working capital that needs to be treated, protected and invested in. A range of solutions needs to be employed. There needs to be more effort at mental health promotion aimed at both individuals and organisations. Organisations must focus on providing healthy and supportive working environments. They need to focus on employees' health and mental well-being, invest in continuing training at all levels of the organisation, engage workers in dialogue so that problems can be identified and discussed, monitor absenteeism and identify the underlying causes and problems early, identify vulnerable workers and adopt a case management approach to find best solutions to individual cases, adopt flexible work opportunities which enable a healthier work-life balance and enable return to work, and provide supported/sheltered employment for workers with more severe mental disorders. This integrative approach requires a continuing collaboration between health, employment, and social sectors through effective legislation and policies to optimise economic effectiveness and social cohesion.

Symposium "Health Literacy – Strengthening Self - Management of People with Chronic Illness" University of Bielefeld, 30-31 October 2014

The Health Literacy debate is crucial because it puts new and long–ignored topics on the agenda. It is becoming increasingly important to consider contemporary

implications for health literacy as a means to improve quality of life throughout the life-course. Most often, governance systems are not only short in offering protection and enhancing capabilities; in some cases they are producing new vulnerabilities (UNDP, 2014).

To bridge the gap of the European health literacy challenge, professionals need to acknowledge their role in fulfilling people's needs, hence the need for further investment in capacity building. The further integration of health literacy into disease care, disease prevention and health promotion calls for:

- Sustained political support
- Instruments for measurement and implementation
- A strengthening of organizational capacities infrastructures and resources
- Legal requirements and financial incentives
- Integration into professional training and further education
- Scientific support (data, evidence)
- Organization of networking and exchange between all stakeholders.

Nurses play a major role in providing leadership that meets the challenge of low health literacy in our society, both at the individual level of care and within organizations. Family caregivers as the backbone of home care are also in need of competence in health issues.

Youth Mental Health Conference, Venice, 16th to 18th December 2014

This 3 day conference organised under the auspices of the Italian Presidency of the EU focued on the transition from continuation of psycholpathoogy to continuity of care. The challenges of epidemiology of adolescent psychiatry were discussed in the context of the longer term gains linked to early intervention in the course of mental disorders in young people. Basic sciences and genetics are focusing on brain development in utero and brain changes in the transition from childhood to adulthood leading to a better understanding of mental disorders. Continuity of care is a major challenge for the organisation of services and the development of youth psychiatry as a subspeciality to deal with mental disorder in persons less than 25-30 years of age is slowly evolving in the more developed countries, such as Australia and

Canada. The conference also focused on prevention and promotion with particular attention to schols and universities and importance of tackling violence, bullying and substance misuse.

This Office continued to contribute to Malta's perspective within the **European Hospital and Healthcare Federation (HOPE)** by providing the liaison officer within the Maltese delegation for HOPE. HOPE is a non-governmental, not-for-profit European association. HOPE seeks to promote improvements in the health of citizens of the European Union by promoting high standards of hospital care through the fostering of efficiency, effectiveness and caring attitudes in organisations responsible for the operations of hospitals and of the health systems within which they function. As part of its activities for 2014, HOPE is monitoring progress on the Directive on the application of Patients' Rights to Cross-Border Health Care, and updating Country profiles accordingly. Other topics discussed included the impact of the Directives on public procurement, professional qualifications, co-payment of hospital care, European workforce for Health and Working time directive. An emerging new priority in healthcare is emergency care and HOPE wants to study the situation in its member countries. To this effect HOPE invited all liaison officers to contribute to the development of a questionnaire on the topic and to complete the questionnaire with the competent persons.

Chapter 3: Professional Development

The Office is committed to the professional development of all staff and to their contribution to the professional development of others. This it achieves by encouraging the uptake by staff of continuous professional development activities and their regular involvement in academic and professional development of others. This helps staff to improve their skills and expertise to implement the mandate of the Office and deliver a quality service.

Continuous Professional Development

Throughout the reporting period, a number of training initiatives were taken up by various staff members. These include:

- Diploma in Public Management – University of Malta and CDRT Course (Completed successfully in 2014).
- CDRT course on the use of Windows 8 (February 2014).
- Workshop on priority actions from the Food and Nutrition Policy Action Plan delivered by Dr Charmaine Gauci, Director, Health Promotion and Disease Prevention (1st April 2014).
- Health Inequalities & Environment – actions for the National Environment & Health Action Plan (NEHAP) delivered by Dr Christine Baluci, Resident Specialist Public Health Medicine (8th April 2014).
- Royal College of Physicians Edinburgh Symposium: Use of evidence in health inequalities policy, organised through video link by the Postgraduate Medical Centre MDH (8th May 2014).
- Ethics in the Public Sector organised by CDRT (16th May 2014).
- Self management in chronic diseases by Dr Mariella Borg Buontempo, Consultant Public Health Medicine (20th May 2014).
- Educational supervision and assessor training organised by Foundation School Directors Prof. Kevin Cassar and Dr Tonio Piscopo (27th May 2014 and 29th May 2014).
- EU funding training organised by MEUSAC (17th June 2014).
- mHealth delivered by Dr Hugo Agius Muscat, Consultant Public Health Medicine (26th June 2014).

- 3-session course on Managing with Leadership organised by CDRT (June / July 2014).
- 2-session course on Writing Skills organised by CDRT (July 2014).
- Investing in trainees and training: a train the trainers event, delivered by Dr Premila Webster, External Assessor of the Postgraduate Public Health Medicine Training Programme Annual Assessments (22nd September 2014).
- Crisis Communication by Dr Ray Busuttil, Consultant Public Health Medicine (14th October 2014).
- Conflict Resolution organised by CDRT (15th October 2014).
- CPD requirements by the Faculty of Public Health UK, by Dr Muna I Abdel Aziz, International CPD Coordinator, Faculty of Public Health, UK, organised by Dr Sandra Buttigieg, Consultant Public Health Medicine (12th December 2014).
- 3-session course on Desktop Publishing (December 2014).

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:

- Planning, coordination and lecturing of the module PHL5126 - Organisation of Health Care Systems and Management (5 credits) of MSc in Public Health Course organised by the Faculty of Medicine and Surgery of the University of Malta.
- Delivering lectures on Pharmacoepidemiology and Health Status of the Elderly in other modules of the MSc in Public Health Course.
- Educational supervision of two foundation doctors.
- 3 Practical tutorial sessions to postgraduate public health medicine trainees on Poverty (3rd July 2014), on Health Literacy (4th August 2014) and on Ageing: a threat or a blessing? (30th October 2014).
- Member of the Annual Assessment Panel of the trainees in the Public Health Medicine Postgraduate Training Programme.
- 2 Members on the Executive Committee of the Malta Association of Public Health Medicine.

- 3 Members of the Public Health Postgraduate Training committee representing the Malta Association of Public Health Medicine (2 members) and the University of Malta (1 member).
- CPD lecture – “Mental Health Act for Public Health Physicians” as part of the CPD programme for public health physicians organised by MAPHM (17th November 2014).
- Lectured and examined undergraduate Medical Students following the Public Health module of the M.D. Course of the University of Malta on the political aspects of care and the role of the clinician in management.
- Lectured B.Sc. Community Nursing students on Community Care of the Elderly.
- Lectured B.Sc. Psychiatric Nursing students on the Mental Health Act.
- Assistance of a number of postgraduate (PhD, Mphil, MSc) trainees in various disciplines (pharmacy, public health, psychology, economics) as part of their thesis or research (piloting, validation, participation).

APPENDIX 1

Functions of the Commissioner

(Article 6 (1) of the Mental Health Act 2012)

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;

(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

OFFICE OF THE COMMISSIONER FOR MENTAL HEALTH AND OLDER PERSONS

REPORT

"Mental Capacity in Maltese Legislation"

Reflection Seminar held under the auspices of H.E. The President of Malta on 22nd February 2014

Verdala Palace
Buskett

26th December 2014

Mental Capacity in Maltese Legislation

The need to look at Mental Capacity in the light of current Maltese legislation and what changes are necessary in order to give adequate protection to vulnerable people who lack mental capacity in the absence of Mental Disorder was the theme of this seminar. The Seminar was held under the auspices of His Excellency the President of Malta Dr George Abela on the 22nd February at Verdala Palace in Buskett, Rabat.

Introductory remarks

According to the Mental Health Act "mental capacity" *means the patient's ability and competence to make different categories and types of decisions and to be considered responsible for his actions*. His Excellency the President of Malta Dr George Abela explained that he views this seminar as a means of raising awareness to an issue which touches the most vulnerable people at the core. His Excellency urged politicians to look at the necessary legislation which has the people and their protection as its basis.

On a similar note was the position expressed by the EU Commissioner for Health and Consumer Rights Dr Tonio Borg who stressed that this theme was in line with EU actions and in agreement with the EU paper on Fundamental Rights that in front of the law everyone should be treated equally and not discriminated against. He spoke of various EU initiatives in the field of mental health and reminded of EU funding opportunities for research and implementation of adequate practices for the improvement and safeguarding of the more vulnerable in society.

The Speaker of the House of Representatives Dr Anglu Farrugia appealed to the professionals working with people who have a temporary or transient problem of Mental Capacity including doctors, notaries and lawyers to act in the best interest of the person in the absence of formal protective means in legislation. He reminded of the existing legislation regarding interdiction and guardianship whilst at the same time he stressed on the importance that one is to ensure that the curators and guardians are meeting their legal obligations. Dr Farrugia appealed to the ethical principles guiding the professionals when they are faced with the dilemma whether a person is mentally capable or not of making decisions as understanding the consequences of these decisions. He concluded by mentioning the introduction in Malta of legislation and/or mechanisms such as Advanced Directives, lasting powers of attorney practices and assisted decision making.

The seminar was addressed by the Minister for Health Dr Godfrey Farrugia who explained how health problems may arise leading persons to be in a position where others have to take decisions on their behalf and how sometimes these situations may strip persons of their rights and dignity. He encouraged the health and other professionals dealing with the person to take their time to ensure that the wishes of the person are being taken into account and safeguarded in all aspects including the health care services provided.

Keynote address

Chief Justice Emeritus Vincent De Gaetano gave the key note address at this seminar. He highlighted the developments in the legal framework from practices in the early 70s where a person's mental capabilities depended upon the final word of the psychiatrist to a more holistic framework which takes into consideration various aspects of the person's life and abilities. He described the words 'mad', 'of insane mind' and in a 'state of madness' as expressions which were built on medical jargon and which had a very negative connotation on a social aspect. He based his speech on 3 main items : an overview of relevant

legislation from Maltese and European laws, an overview of definitions from these laws which were relevant to lead to the following discussion by panel of experts and lastly lessons which can be learnt from the European Court of Human Rights which can help in the local context and scenario.

The first legislation dealing with Mental Health in Malta was the Mental Health Act (Cap 262) of 1976 which was enacted in 1981. Over the years this law was followed by other legislation which improved the language used in the text, such as the Equal Opportunities act which changed the definition of mental health issues from a purely medical model to a more social interactive model by removing words such as 'mad', 'sick mind' and 'state of imbecility' to more acceptable terms. He explained in detail other implications of this law on other legislation with the definition given of 'disability' and the rights and duties this new definition gives in practice to persons suffering from a disability. Chief Justice Emeritus De Gaetano focused on the positive changes brought about by the Mental Health Act (Cap 525) which was enacted in October 2013 and comes in full-force in October 2014. He explained that the list of rights given by law and the social aspect of the new law are a considerable improvement on the old law which basically listed how a person was to be detained. He outlined similarities between this law and others such as the Civil Code where together this legislative framework acts to safeguard the person's rights whilst at the same time offering protection to self and others. He spoke of the situation where restrictions are legally applied on the basis for the protection of health or for the protection of the rights and freedoms of others, however this has to be kept to the essential minimum.

Referring to the Mental Health Act (Cap 525) – Chief Justice Emeritus DeGaetano described this act as a very positive step forward especially since in the very first section of the law it outlines a list of patients rights – these rights are favourable for the client since if he feels aggrieved by any actions the law is a tool for him to seek compensation without the need to go through complicated legal procedures. The fact that the responsible carer is broader than the old concept of next of kin is a further positive development which offers safeguards. An important improvement which is brought about by the new Mental Health Act which critical for the seminar topic was the clear distinction between Mental Illness and Mental Capacity, where it is now established that these can exist separately and thus a person with a mental disorder can still have the ability to take decisions. He referred specifically to Article 24 of the law which recognises that the person who suffers from Mental illness can still decide on aspects important to his life e.g. decisions about his status and financial aspects amongst other things. He viewed the law as giving a sound basis and protects the person with regards to mental capacity by placing obligations on the Commission that the verification of certification of incapacitation is done by an independent specialist. The law also provides measures for the reversal of incapacitation and interdiction and other means to ensure that there is no abuse. However the question arises when there is a query about mental capacity which does not fall or is not covered by the Mental Health Act and this is a lead consideration to be made in highlighting the negative aspects of the new Act.

Whilst the role of Commissioner is being heavily laden with responsibility, within the law there are no specific qualification requirements for a person to occupy this position, has no security of tenure and is responsible to evaluate the service delivery given by the public authorities whilst at the same time, the commissioner is accountable to the Minister of Health for the execution of his performance. This accountability partially hinders the impartiality of the position of the commissioner, more so with regards to the change brought about by the removal of the Mental Health Tribunal to evaluate and decide on the detention or release from a mental health institution of a person and placing this within the responsibility of the commissioner. There are measures within the Maltese Constitutional court which ensure a fair process although Chief Justice Emeritus DeGaetano stated that these may not be enough to meet the obligations of Article 5(4) of the Human rights convention. It has

repeatedly been noted by the European Court of Human Rights that this Article is not met on the basis of timeliness by the Maltese Courts.

The third negative aspect highlighted is the list of obligations of the curators which are already regulated by other legislation. There are already other obligations which these curators need to meet under the Civil code and additional burdens may hinder persons who genuinely would like to act as curators for interdicted and incapacitated persons due to a mental disorder.

Chief Justice Emeritus DeGaetano drew parallels between the Mental Health Act and Guardianship legislation with emphasis on the similarities and differences between obligations of curator and guardian where whilst the first is primarily held responsible for the financial matters the latter is more focused on the welfare of the person. In view of these parallels between the 2 laws the speaker queried whether the different procedures should be revised and joined up into one. He debated the point about the composition and procedures adopted by the guardianship board which could possibly be in breach of the European Convention on Human Rights.

The Court of Protection in England and Wales and the Mental Capacity Act 2005 (UK) were mentioned as examples of entities which take decisions behind closed doors. These do not focus on mental health or mental disorder but focus on the person who for some reason or other is not capable of taking certain decisions and this may be due to dementia, autism or other injury to the brain of a temporary or permanent nature. Procedures held behind closed doors where subject to criticism in the last months due to their controversial nature. However two important learning points from this legislation are the definition of 'Mental Capacity' and the concept of the 'lasting powers of attorney'. In the Maltese Mental Health Act the decision about the person's mental capacity lies totally in the hands of the certifying specialist whilst at the same time the law does not establish any criteria about the what and the degrees of incapacitation. The English law gives the parameters of what and for what the person is incapable of taking decisions. This leads to the second point concerning 'lasting powers of attorney'. In Maltese law there is the possibility of appointing someone to act on one's behalf, however this power is null if the person becomes incapable of taking decisions by court decree or otherwise and there are no provisions to see that the person's wills are followed through when the person's mental abilities deteriorate or the person is in a permanent state of coma. This is safeguarded in the English legislation, which gives the option of the lasting powers of attorney which establishes that the donor can give to someone the powers to look after matters of personal welfare and property in the circumstance where the donor no longer has the capacity to deal with such matters. This means that in English law power of attorney is given when the person has full mental capacity and this remains active in the circumstance of the person loosing the abilities to take decisions. This is highly regulated in the English law so as to avoid abuse and hardships on the donor.

The concluding remarks were focused the important aspect of human dignity which is not specified in the Convention of the European Rights but is found in the EU Charter of fundamental rights. *Article 1* states that **Human** dignity is inviolable. It must be respected and protected and this is amplified in *Article 2* concerning the right to life which states that everyone has the right to life and no one shall be condemned to the death penalty, or executed. This enforces the respect for the person from the slightest hint of conception to the last remaining bones of a being and only with these principles in mind can one open a debate on capacity or incapacity. These are the standards for protection of the person which Malta has subscribed to by signing various international treaties which regulate even our parliament in its legislative work.

The full text in Maltese of Chief Justice Emeritus De Gaetano's speech is available on https://ehealth.gov.mt/HealthPortal/others/officeofthecommissionerformentalhealth/mental_capacity_seminar/seminar_presentations_and_proceedings.aspx

Panel Presentations

Presentations were made by Dr. Daniel Bianchi on behalf of the Chamber of Advocates, Rev. Prof. Emmanuel Agius, Ethicist, Dr. Antoine Vella, Consultant Geriatrician, Dr. Annalise Micallef for the Chamber of Notaries and Prof. David Mamo, Consultant Psychiatrist. The Panel Discussion was chaired by Dr John M. Cachia (Commissioner).

Empowerment: Persons who are vulnerable as a result of mental or physical disability or because of a degree of mental incapacity due to a variety of conditions such as having dementia, particularly in its early stages; having difficulties with speech or writing; having learning difficulties; or being vulnerable or at risk from himself or herself or others do not fall under the mental Health Act. Regulatory and legal systems that already exist and those that are in process such as the guardianship act, advance care directives and living wills are essential to empower rather than to restrict these vulnerable individuals.

Empowerment should underpin the guiding principles applied in deciding which measures will be most suitable for meeting the needs of the individual. The same guiding principles must also be used whenever decisions need to be made on behalf of the adult. The aim is to protect people who lack capacity to make particular decisions, but also to support their involvement in making decisions about their own lives as far as they are able to do so.

The guiding principles include:
Principle 1 –There shall be no intervention in the affairs of an adult unless the person responsible for authorising or effecting the intervention is satisfied that the intervention will benefit the vulnerable adult and that such benefit cannot be reasonably achieved without the intervention.
Principle 2 – Where an intervention in the affairs of an adult is to be made, such intervention shall be the least restrictive option in relation to the freedom of the adult, consistent with the purpose of the intervention.
Principle 3 – In determining if an intervention is to be made, and, if so, what intervention is to be made, account shall be taken of the present and past wishes and feelings of the adult so far as they can be ascertained by any means of communication, whether human or by mechanical aid (whether of an interpretative nature or otherwise) appropriate to the adult. Before concluding that someone is totally unable to communicate and therefore lacks capacity, strenuous efforts must be made to assist and facilitate communication – using whatever method is appropriate to the needs of the individual, including advice and assistance from a speech and language therapist. It is important to note that it is compulsory to take account of the present and past wishes and feelings of the adult if these can be ascertained by any means possible.
Principle 4 – In determining if an intervention is to be made, and, if so, what intervention is to be made, account shall be taken of the views of the nearest relative and primary carer of the adult, or a named person, or any guardian, attorney or curator of the adult who has powers relating to the proposed intervention.
Principle 5 –Any guardian, attorney or curator should encourage the person to exercise whatever skills the vulnerable adult has concerning property, financial affairs or personal welfare as the case may be, and to develop new such skills.

Empowerment means giving elderly and persons with disability better control over their lives including their health when they are still well enough to do so in preparation for a time when they might not be capable of doing so. Empowerment can guide vulnerable adults to decide

early on what to do if in the future, they cannot take decisions regarding their estate, their residential requirements and their care and health.

Assisted Decision Making: This seminar dwells upon questions concerning decision making, in particular decisions regarding health and care of people have a lack of mental capacity. When one has the legal capacity to consent to receive care, the issue dwells around professional advice on treatment options. This can also be assistance to persons to exercise legal capacity. But what happens when this is not possible? What happens when patients cannot decide on their own, at the time when a decision is needed whether to proceed with care or treatment? On what basis will a decision be made in such circumstances? What is the guidance on the decision?

An option available nowadays, which is not covered by the laws of Malta, is the principle of "advance directives". Through advance directives, a person can determine decisions today on what might arise in the future when not in a position to take such a decision, about for example refusing or giving prior consent to particular care or treatment given such the situation occur.

The use of advance directives varies between jurisdictions. A decision taken by a patient using an advance directive may have the same binding effect of a decision taken only as and when required at a particular point in time. One must recognise that such mandatory obligations cause issues to the treating team. The patient is given a tool to express and take decisions which otherwise cannot taken by the patient when actually needed those decisions himself. The choice of the effect of advance directives in terms of mandatory obligations on the caring professionals and the caring others remains in the hands of the legislator.

It is appropriate to mention the limits of advance directives. Certainly they do not solve all problems. For example, one must have determine at what point in life a person possesses the necessary mental capacity to formulate advance directives. If one never had problems of lack of mental capacity, then advance directives may be useful for that individual. The availability of complete and exhaustive information and the ability to decide based on that information is often questioned. On the other hand, the use of advance directives is a form of protection for those who must eventually decide, because it alleviates the burden of the eventual decision which can be based on indications or decisions given by the person concerned months or even years before.

It is appropriate that any debate concerning the use of advance directives takes an appropriate amount of reflection, study and thought. It may not be the best option. It is not the only option. But if the reflection is complete, the principle of advance directives is an option among others in relation to decisions to be taken for and on behalf of persons who cannot decide for themselves at a given moment in the future.

Notaries' professional issues: Notaries are in daily contact with vulnerable persons, officiating agreements and deeds whereby persons deliberate on their patrimony. By law, the notary must verify the voluntariness to act of the parties and once all the elements for the deed subsist, a notary is obliged to offer his services. The assessment of volition and understanding by parties to a transaction is the remit of the notary and this, undoubtedly, is in itself a highly subjective exercise, particularly in view of the presumption that a person is deemed capable at law unless proven otherwise. Accordingly, it becomes very difficult to conclude that an individual does not have the required level of discernment necessary to partake in acts and agreements.

Difficulties exist even if one considers interdicted and incapable individuals where there is an official decree on the incapacity of the individual, in practice it is very difficult to ascertain whether a particular individual is interdicted or incapacitated. It is of impelling importance to

have an ad hoc register accessible to practitioners whereby one can readily verify if a person if interdicted or incapacitated. It has become common practice for notaries to request a medical certificate attesting the testamentary capacity of the client in cases where there could be doubt about this. It can be argued that such a practice is tantamount to an admission that the person lacks adequate capacity . The bottom line is that we urgently require legislation and unequivocal guidance on how to act when faced with such commonplace cases.

It is important for our legal system to incorporate instruments such as 'advanced directives' and 'lasting powers of attorney'. We come across situations where these instruments are drawn up and presented and there is absolutely no guidance in our legal system on how to treat these, more so in view of the added benefits these instruments would permit to individuals, empowering them to make decisions for future moments in their lives when it will be no longer possible for them to validly posit their consent. At the outset, this legal development would require the concept of 'consent' and 'capacity' in our law to be broadened to incorporate consent that is conditional on a set of future contingent circumstances . Last but not least, this would precipitate an overhaul of present cultural concepts and a change of approach by the public at large.

In view of the consideration to adequately protect vulnerable individuals, it is strongly advisable to promote the set up of trusts as per Chapter 331 of the Laws of Malta, which are instruments already available in our legislation, that offer comprehensive solutions to vulnerable individuals. Informing individuals of these possibilities is a step forward to breed the cultural change that goes alongside a robust system of protection of vulnerable adults. Ultimately, when dealing with capacity, one can never approach the subject with a 'one size fits all' approach - different acts require a different degree of capacity; different vulnerabilities pose different threats to individuals. It is only by adopting an interdisciplinary approach that the best solutions can be found such that the medical dimension is reflected in a legal system that safeguards the interests of vulnerable individuals while preserving their sense of dignity.

Vulnerability: Action taken in this regard must at all times repect the principles of the Oviedo convention concerning the primacy of the human being over the sole interest of science or society and the protection of human rights and dignity. Health care must be according to needs, and designed to maintain or improve the state of health or to alleviate suffering. Care must be delivered according to standards that reflect scientific progress and be subject to continuous quality assessment.

Elements of good quality include the right to active participaition of the person in the decision making process, the right to free and informed consent, the right to complete and clear information in a format that is understandable by the person concerned, the right to withdraw consent and the right to respect and dignity.

There must be special provisions and added protection in case of minors and adults who are unable to give consent. Again here the underlying principles are added benefit, the least restrictive option should prevail, the autonomy of the person is to be respected at all times and the vulnerable person is to be legally represented in the decision making process. Government policies and bodies must provide protection to people who are unable to make decisions for themselves.

The full text of presentations made by members of the Panel may be accessed on https://ehealth.gov.mt/HealthPortal/others/officeofthecommissionerformentalhealth/mental_capacity_seminar/seminar_presentations_and_proceedings.aspx

Discussion

Key note speech and panel presentations were followed by contributions and questions from the floor. On a query about the basis of certification of Mental Capacity, Chief Justice Emeritus DeGaetano explained that although there is a new Mental Health Act, the decision on assessing the patient's mental capacity still lies on the psychiatrist without giving clear definitions. It is common practice that the psychiatrist makes good judgement and analysis whether the patient is subject to internal or outside pressure when drawing a will. English Law explains that with regards to decisions taken in relation to a particular matter, persons are considered capable if they can fulfil the following:

- Can take a decision
- Understand the consequences of such a decision
- Retain that decision and
- Can communicate that decision.

Individuals without a mental disorder, under UK legislation enacted in 2005, may be entitled to a public guardian, on the advice of the Attorney General and this ensures that there is no abuse on the person by others such as forcing to change a will or other matters.

With regards to the local practice of power of attorney, it was explained that once the person has adequate mental capacity,power of attorney can always be revoked by the person giving these powers. Powers to revoke are extinguished once the said person is declared incapacitated or interdicted. A decree declaring a person's interdiction implies that the person still has full human rights but the person is interdicted from certain civil rights whilst retaining others.

Mental capacity in children was briefly discussed. All minors are perceived to be incapable of taking decisions. Following assessment a Psychiatrist can state if a minor can take a decision. Mental capacity does not refer to the inability to take decisions because of immaturity due to age reasons. Within this discussion on the issue of children giving consent, concern was expressed on how much onus is being given to children giving consent such as the recent Law enacted in Belgium dealing with Child Euthanasia. Kummissjoni Nazzjonali Persuni b'Dizabilita emphasised that not all people are to be put in the same category, and that it must be always assumed that a person has mental capacity until proved otherwise.

On the delicate subject of taking decisions dealing with end of life issues and treatment in severe cases where there may be discrepancies between the wishes of the person and thenext of kin, it was explained that ethical guidance is that the medical team involved must act in the person's best interest and must seek the opinion of next of kin but the final decision lies with the team leader.

Comments collected via feedback forms

Feedback forms were distributed in the participants pack and close to 50% of those who attended submitted the feedback form. Feedback was asked about seminar preparation and logistics, content and participants' expectations. All feedback was positive ranging from good, very good and excellent. This was also confirmed via written feedback on the level of the presentations made by speakers which was positively commented upon. A general comment was that the content was high level and merited more time for expansion and discussion considering its value and possible impact on people's lives. The participants wanted more time for questions and discussion. A recurring comment was that whilst the legal and medical aspects were well represented in the presentations the social and psychosocial perspective of the topic was missing. A recurring suggestion was the request

for presentation of case studies or even real life situations to make the discussion closer to reality and not just theoretical.

Participants were also asked to submit any comments which they did not voice during the discussion or they wanted to submit in a confidential manner. Such comments included the need for clear protocols, guidelines or legislation on mental capacity to give professionals dealing with vulnerable people clear pathways to practise safely and report any abuse if they are aware of this. Examples of situations were given such as people admitted at Accident and Emergency in a state of intoxication or children or elderly who may not necessarily realise that those who are caring for them have secondary motives rather than their care. The development of these protocols or/and legislation need to be formulated with a mutlidisciplinary persective to include a holistic approach. It was also suggested to look at the mechanisms which are being practised in other countries such as the advaced directives or public guardian office. Some participants suggested that professional front-liners dealing with such vulnerable population need to be adequately trained and knowledgeable on rights and ethical issues whilst they are backed by a sound legal framework to enable them to do their duties well.

_____	_____
Ms Gertrude Buttigieg	Dr John M Cachia
Communications' Officer	Commissioner

APPENDIX 3

Report on the Annual Visitation to Licensed Mental Health Care Facilities 2014

Office of the Commissioner for the Promotion of Rights of Persons with Mental Disorders

“Kull persuna hi kapaċi li tagħmel almenu pass wieħed ‘il quddiem,
tieħu kemm tieħu żmien biex titgħallem tagħmel dak il-pass wieħed ‘il quddiem.”

(Every person is capable of making at least one step forward, no matter
how long it takes that person to learn how to make that one step forward.)

1.0 Introduction

1.1 Background

The new Mental Health Act, 2012 was approved by Parliament on the 3rd December 2012 and was endorsed by the President of Malta on the 7th December 2012. The Mental Health Act, 2012, came partially into force on 10th October 2013. The new legislative tool introduces new modalities of care which uphold the dignity of the person. It promotes patient-centred care preferably in the community provided by a multidisciplinary team offered in the least restrictive way and for the least possible time. Moreover, the patients and their carers partake in the care process.

The Act establishes a Commissioner as the authority responsible for promoting and safeguarding the rights of persons with mental disorder. The duties of the commissioner include the approval, review and monitoring of compulsory care, ensuring that the patients are cared for with dignity and in an environment which is conducive to their well being. The law also states that the Commissioner is to perform regular inspections at least annually to all licensed mental health facilities to ascertain that the rights of the patients and all the provisions of the Act are being upheld. In this spirit, the Commissioner conducted the annual visitation for 2014 through a number of visits to licensed facilities between June and September 2014. The findings of these visits are being summarised in this report.

1.2 Aim

The main aim of the visitation was to ensure that the care provided in mental health facilities supports the dignity and rights of persons with a mental disorder as provided by the Mental Health Act. This was the first formal visitation as required by the Act to be conducted by the Office of the Commissioner since 2014 was the first full year of operation of the Commissioner under the new law. The intention was to get a broad brush view of the care being offered and the facilities from where it was being delivered. Future annual visitations will build on these findings and would include a more detailed review of specific aspects.

2.0 Methodology

2.1 Team Composition

All visits were led by the Commissioner himself supported by two teams of three persons each from the Office, coming from different professional backgrounds namely legal, medical, social and

community care. This mix of professionals provided for a more holistic assessment of the facilities visited.

2.2 Visits

The visitation to the licensed mental health facilities was conducted between June and September 2014. For completeness, the visitation included also community based services, which are currently not included in the list of licensed mental health facilities. In all, seventeen (17) visits were performed and forty-six (46) different provider units were visited. The Office communicated the date and time of the visit to the respective facility and once this was suitable to the facility, the visit was confirmed. The detailed timetable of the visits is in Annex 1.

The facilities visited may be classified as follows:

2.2.1 Hospital Settings

Mount Carmel Hospital

- 13 wards/units providing acute, chronic, rehabilitation care for adults and also for minors
- Occupational Therapy, Physiotherapy, Psychology and Social Work Departments
- Customer Care Office, Pharmacy

Gozo Hospital

- Long and short stay wards
- General Paediatric ward (wherefrom psychiatric care is offered to minors)

Mater Dei Hospital

- Acute Psychiatric Unit
- Psychiatric out patients
- Crisis Intervention Unit

2.2.2 Community based Centres/clinics:

- Outreach centre
- Day Centres at Cospicua, Floriana, Paola, Qormi and Zejtun
- Day Clinics at Cospicua, Floriana, Mtarfa, Paola and Qormi
- Child Guidance Clinic
- Roaming team working within the Mosta and Gzira health centres

2.3 The Tool

A template was prepared with the aim of facilitating the evaluation of the ward or facility that was being visited. One template was completed for every location. (Annex 2)

Assessment of the wards/units/facilities consisted of three main domains namely observation, interviews with staff and service users and reviews of patient documentation.

2.3.1 Observation

Much information may be deducted through observation of the general ward environment, patient appearance, behaviour and interaction between staff and patients. We believe that dignified care precludes an environment which is safe, clean and has the necessary basic comforts conducive to overall well-being. Also, the general upkeep of the patient and the way that staff interacts with the patient reflect those intangible aspects of care that determine if a patient is being treated with dignity and respect.

2.3.2 Interviews

Interviews were conducted with the lead healthcare professional, the charge nurse or his/her deputy on wards or the lead healthcare professional in community services. A few patients from wards and day centres were selected randomly for interview. In day centres, the visit included also an interactive discussion with the group of service users who in some cases were accompanied by their responsible carers.

2.3.3 Documentation

In all care facilities that retained patient files, two to three files were randomly selected for review. Treatment charts were also appraised on wards. Appropriate documentation of patient records is a good indicator of care. The main indicators that were assessed were organisation of the file, clarity of patient diagnosis and type of admission and the date of last medical and nursing entries. In the case of involuntary admissions the appropriate completion of forms and clear evidence of the expiry of these admissions was sought. Furthermore, presence of patient consent forms, responsible carer forms and documentation by a multidisciplinary team were noted.

3.0 Findings

During all visits the Commissioner and his team had unrestricted access to all parts of the licensed facilities and all patient medical records as well as the necessary facilitation to interview patients in private. All management and staff members involved in this process deserve praise and appreciation for the courteous and collaborative approach they have taken.

The aim of the visitation was to determine if the patient is receiving care with dignity and respect, and that the rights of the patient listed in the Mental Health Act are being upheld.

Areas of good practice were immediately highlighted by the visiting team. In those areas which needed immediate action, the facility concerned was advised to take specific corrective measures or to provide additional documentation. An unannounced follow-up visit was carried out on 7th October 2014 in order to verify progress in these areas and in most areas action had been taken.

3.1 Compliance with the Mental Health Act

The table below focuses on the level of compliance with the rights listed in Article 3 of the Mental Health Act. Our assessment is based on observations carried out during planned visits to the various facilities within a limited timeframe and in the presence of ward or unit management staff. Further evidence was collected from information and documentation provided by staff, examination of patient records and private interviews with service providers and users.

Since patient rights can more easily be overlooked in hospital settings, our observations are mainly focused on the hospital settings. However issues pertaining to community based facilities are referred to where relevant.

	RIGHT	SITUATION
A	exercise all civil, political, economic, social, religious, educational and cultural rights respecting individual qualities, abilities and diverse backgrounds and without any discrimination on grounds of physical disability, age, gender, sexual orientation, race, colour, language, religion or national or ethnic or social origin	**Positive -** No evidence of discrimination could be elicited; alongside the chapel a multi-faith room is available **Negative -** language can be a barrier for foreigners; no cultural mediators available for asylum seekers; religious services are not easily accessible to all patients **Additional Comments / Recommendations –** wards where social care only is required should be declassified from psychiatric facilities and re-classified as residential accommodation for long term care

B	receive treatment of the same quality and standard as other individuals	**Positive –** from charting and documentation inspected and from private interviews with patients the evidence is that the level of medical and nursing care are comparable with practice elsewhere **Negative –** long lists of medicines prescribed to patients in most chronic and rehabilitation wards need to be revisited regularly - the copying of treatment charts month after month without regular medication review is not good practice **Additional Comments / Recommendations** – patients with general medical and geriatric care needs should benefit from the inputs of specialists in internal medicine and geriatrics as is common practice in other non-psychiatric hospital and residential settings. This may obviate the need to refer such patients to Mater Dei Hospital for specialist care as happens currently.
C	receive treatment which addresses holistically their needs through a multidisciplinary care plan approach	**Positive** - documentation shows that multidisciplinary care is predominantly provided by nurses and doctors in acute wards; care is predominantly nurse-led in chronic wards; in community services the lead roles seem to be taken by nurses and occupational therapists; the Intellectual Disability Rehabilitation Unit is an excellent model of multidisciplinary care practice that should be followed for other patient groups **Negative** – the patient experience in wards needs to improve - the level of stimulation and activity on a daily basis seems to be low (in most cases this consists of a daily bath, and then sit-stare-smoke-watch TV until it is time to either eat or sleep); patient and responsible carer involvement seems to be very limited; rehabilitation is selective and distant from the ward environment; a fully equipped gymnasium in Female Ward 1 is practically unutilised **Additional Comments / Recommendations –** better holistic care through the contribution of all health care professionals, the inclusion of the patient and the responsible carer; the re-classification of wards into acute, rehabilitation, residential, chronic (geriatric and medical); the creation of more specialised units for specific care needs (e.g. adult rehabilitation; child and adolescent mental health) on similar lines as has been

		done for eating disorders
D	receive treatment in the least restrictive environment and in the least restrictive manner	**Positive** – no evidence of abuse of restrictive care; the open door policy adopted in the Long Stay Ward in the Gozo Hospital merits special mention **Negative** – ample internal garden space and walking pathways adjoining hospital wards are poorly kept and largely underutilised; patients are largely confined to the general ward area; as disclosed during patient interviews, ward staff sometimes resort to threatening patients with seclusion in time-out rooms or other punitive measures such as restricting access to main garden and activity centres as a behaviour control measure **Additional Comments –** The Mental Health Act stipulates that use of seclusion is regulated by protocols. The protocols and their implementation will be examined in further detail by this office.
E	receive care primarily in the community	**Positive –** dedication and motivation among staff and appreciation by users were evident where it is being offered – Floriana, Qormi, Paola, Cospicua, Zejtun; mainly focused on day centre activities and nursing care follow up of users **Negative –**over-subscribed and thus cannot support new urgent referrals by GPs and family doctors; consultant-led service that is restricting access; discriminatory on the basis of residence with no service in the South Western, North Inner Harbour and Northern Regions **Additional Comments / Recommendations** – more investment is needed in community mental health facilities and preventive mental health; more varied interventions aimed at empowering patients to be more autonomous
F	aftercare and rehabilitation when possible in the community so as to facilitate their social inclusion	**Positive –** nil to report in hospital settings; see Section E regarding community based services **Negative** – crisis intervention team and outreach services are ineffective; 30-40% of patients lapse Psychiatric OP appointments; on a daily basis up to 25 patients living in the community are collecting their

		medication supplies from Mount Carmel Hospital Pharmacy rather than a neighbouring pharmacy through POYC **Additional Comments / Recommendations** – occupational therapy should focus more on life-skills, job coaching, cooking, computer, home management
G	be adequately informed about the disorder and the multidisciplinary services available to cater for their needs and the treatment options available	**Positive –** use of consent forms slowly improving; the Forensic Ward is an example to follow in this regard with inmates and their families regularly informed and involved in care **Negative** – evidence shows that some wards and certain staff members fail to appreciate the importance of eliciting and recording informed consent; others view informed consent as merely a paper exercise **Additional Comments / Recommendations –** more staff education initiatives are needed focusing on the development of a culture for patient information, engagement and empowerment
H	actively participate in the formulation of the multidisciplinary treatment plan	**Positive** – the multidisciplinary approach is visible and evident on ward rounds with consultants and teams discussing issues in the presence of patients and carers **Negative –** it is a pity that the formalisation of this approach and process is not appropriately and holistically documented; psychologists, social workers and to a lesser extent occupational therapists do make regular entries in patient medical records – they keep detailed notes which are filed separately in their offices; this practice is not conducive to a holistic approach **Additional Comments / Recommendations –** the introduction of a multidisciplinary care plan template would facilitate this process
I	give free and informed consent before any treatment or care is provided and such consent shall be recorded in the patient's clinical record.	see Section G above
J	have a responsible carer of their choice	**Positive** – records in community services are mostly aligned to this concept

		Negative – the "next of kin" concept is still ingrained in the mind of staff – the new law empowers patients themselves to appoint in writing a responsible carer of their choice; the formal appointment of responsible carers needs to improve in hospital settings; the details of the curator of interdicted / incapacited patients are not routinely recorded in the medical record **Additional Comments / Recommendations** – staff education initiatives need to emphasise the importance and the role of the responsible carer or curator in patient representation, in the safeguarding of patient rights and in continuity of care
M	be informed within twenty-four hours of admission to of their rights	**Additional Comments** – to be looked at in future visitations
N	full respect for their dignity	**Positive** – during our visits we could witness mutual respect between staff and patients; in hospital settings, patients were generally clean and groomed and this is evidence of regular practical assistance by staff; clothes worn by patients were clean and wearable **Negative –** some patients do not even have personal belongings; the lack of a personal cupboard in some wards must be assessed against the real rather than the perceived ability of patients to take care of themselves and their belongings; a handful of staff members need to be reminded about the importance of self-grooming and self-respect **Additional Comments / Recommendations –** as part of the therapeutic engagement process patients should be allowed better choice and control in their everyday personal and care needs
O	protection from cruel, inhuman and degrading treatment	**Positive –** No evidence of cruel, inhuman or degrading treatment could be elicited; protection mechanisms such as incident reporting, seclusion registers and customer care are in place **Negative –** under reporting and poor quality of reporting of incidents in some cases **Additional Comments / Recommendations** –the introduction of the regular reporting of near-misses should be considered; all professionals working with

		patients should increasingly focus on ensuring that patients are informed about their rights, including their right to lodge complaints and the mechanisms for doing so
P	privacy	**Positive –** varies from ward to ward and from case to case; the balance between privacy and risk can be very delicate in certain situations; the ideal situation is the Psychiatric Unit at Mater Dei Hospital **Negative –** not easy to distinguish between different patients' needs in wards where there is a wide spectrum of variation; the lack of partitions between beds in all dormitories should be revisited**;** belongings in bundles or plastic bags near beds speak volumes **Additional Comments / Recommendations –** see Sections R and S below
Q	a safe and hygienic environment	**Positive –** the environment, structure and furnishings of the Psychiatric Unit and the Psychiatric Out Patients' at Mater Dei Hospital should be the standard for care of psychiatric patients in a hospital setting **Negative –** the overall ambience of the wards at Mount Carmel Hospital, except for the newly decorated ones, is austere and dated but provided the basic care needs; the level of cleanliness varied between wards, with some wards needing improvement in cleaning standards; Some wards were in more urgent need of maintenance for leaking roofs and damp walls; some bathrooms, including those in Gozo need upgrading as there were missing tiles and rusty baths; some bathrooms at Mount Carmel Hospital lacked the basic requirements such as access to flushing (especially in seclusion areas), wash hand basin, hand soap and toilet paper. **Additional Comments / Recommendations –** the building and infrastructure support services in Mount Carmel Hospital and in the mental health wards of Gozo General Hospital need extensive investment for proper refurbishment. See also Section D and N.
R	free and unrestricted communication with the outside	**Positive** – pay-phone access in all wards and units facilitate communication of patients with the outside world; patients are helped by staff to use telephone

	world	facilities **Negative –** the use of mobile phones and other personal devices is generally not permitted in wards with some exceptions **Additional Comments / Recommendations –** communication should be improved so that patients remain in contact with their relatives and friends and au courant of what is happening around them – this prevents isolation and institutionalisation
S	receive visitors in private within all reasonable times	**Positive –** present in some wards **Negative –** more privacy needed in other wards **Additional Comments / Recommendations –** full implementation should be fairly easy given the extensive size of most units.

3.2 Further comments and recommendations in the interest of patient-centred holistic care

A number of overarching issues have been elicited through our observations, discussions and interviews which need to be addressed in the interest of patient-centred holistic care and which might not have been captured in the above analysis.

3.2.1 Seamless care

Better communication between care providers in the hospital setting and in community based services is essential. The approach taken by service providers in the Gozo mental health service is commendable, but communication is lacking and piecemeal in the rest of the mental health service. Some services are fragmented whilst others are duplicated and this leads to confusion and gaps in service access by patients. Better efforts at service integration are recommended.

3.2.2 Specialisation

The patient would benefit if care provided by psychiatric teams moves towards subspecialisation as has happened in other clinical areas. This may require further training of team members where subspecialty interests have already been identified and implemented through consultant appointments.

In order to ensure focused and timely intervention, early discharge and social integration of the patient, Acute Psychiatry needs to be developed and Rehabilitation Psychiatry needs to be revamped.

This move towards specialisation should be undertaken together with re-classification of the current in-patient population. As commented in Section C above, patients in hospital settings would benefit

if placed in their appropriate care environment [acute, rehabilitation, residential, chronic (geriatric and medical)] and the creation of more specialised units for specific care needs.

3.2.3 Specifically regulated patients

There are two distinct groups of patients whose mental health care is also subject to other regulations: CCF inmates under prison regulations and asylum seekers under detention policies. Both groups of patients benefit from the same level of care as received by other in-patients at Mount Carmel Hospital. However the ambience within which care is provided is grossly inappropriate due to overcrowding in the Forensic Ward for CCF inmates; and due to segregation in delapidated single cells with limited possibilities for social interaction and no provision for any activities in the Asylum Seekers Unit. Asylum seekers are further isolated due to the lack of cultural mediators. Definite improvement is needed in both of these areas.

3.2.4 Child and Adolescent Services

With regards to the Child Guidance Clinic, early consultation with a psychiatrist is possible through an urgent referral system whereby the General Practitioner contacts the service directly. On the other hand less urgent referrals can take up to two years before being seen by a psychiatrist. This state of affairs is unacceptable and needs to be reviewed immediately.

The Young People's Unit has been under the focus of this Office since its inception in 2012. The issues of mixed diagnostic categories in the same ward environment persist. The lack of appropriate seclusion facilities remains, so much so that supervised admission of youngsters in adult wards still occurs occasionally. Adolescents with challenging behaviour have the right to adequate aftercare and rehabilitation in the community leading to their social integration. Our recommendation remains that this is best achieved through specific supervised residential facilities in the community.

On a positive note, it was observed that all youngsters were being engaged in specifically designed programmes during the day which is a welcome step that augurs well for more intensive action needed by children and adolescents.

3.2.5 Documentation

Documentation reflects quality of care. As a general rule, the organisation of files needs to be improved. In fact, the medical diagnosis and the type of admission of the patient could not be easily retrieved. No concrete evidence of multi-disciplinary care provision could be found in these same files.

Regular entries in patient files were logged on acute wards but were relatively sparse and occasionally absent in some rehabilitation wards. Although consent forms, in line with the new Mental Health Act were available in some files, most of them were not completed satisfactorily. A form merely indicating the name of the responsible carer was found in some of the files. Eliciting informed consent and involvement of responsible carers are two important patient rights that underpin the Mental Health Act.

4.0 Conclusion

The aim of the visitation was to determine if patients are receiving care with dignity and respect and that their rights are being upheld, so the aspects of care that were noted included the environment within which the person received care, suitable documentation of the care provided, positive patient experience, privacy, autonomy, communication and social aspects of care. As a general rule there was wide variation in the ambience and quality of care but in most cases the basic needs of the patient were satisfied. The leadership skills and dedication of the lead health care professional was the common denominator that determined the quality of service being delivered in that particular ward, unit or facility.

Observation and discussion with health care providers showed that in general staff in the more acute wards and in the community were more motivated. This was reflected in their enthusiasm and interaction with their clients. However, in most sectors, staff also complained of shortage in human resources especially in the areas of psychology and social work and consultants claimed that these were the main factors barring the formation of multi-disciplinary teams conducive to multi-disciplinary care, as required by the Mental Health Act.

The ultimate goal is to shift care from restrictive hospital settings to more open supported care in the community. The implementation of the recommendations in this report should empower persons with mental disorders to be more autonomous, to lead a more dignified life and to be productive members of society.

JM CACHIA **29th January 2015**
Commissioner

ANNEX 1

Schedule of Visits to Mental Health Licensed Facilities according to date of visit

DATE	UNITS
16th June 2014	1. Female Ward 7 2. Female Ward 8 3. Female Ward 2
19th June 2014	4. Forensic Unit and Maximum Security Unit 5. Male Intravenous Drug Users Unit
23rd June 2014	6. Male Ward 7 7. Male Ward 3B 8. Half Way House
26th June 2014	9. Male Ward 1 and Secure Unit 10. Male Ward 2
30th June 2014	11. Physiotherapy Department 12. Mixed Admissions Ward 13. Asylum Seekers Ward
3rd July 2014	14. Qormi Day Centre (San Bastjan) 15. Qormi Health Clinic (Qormi HC)
7th July 2014	16. Pharmacy 17. Psychology Department 18. Social Work Department 19. Intellectual Disability Rehabilitation Unit 20. OT Department
10th July 2014	21. Cospicua Day Centre (GG Square) 22. Cospicua Health Clinic (Cospicua HC)
14th July 2014	23. Psychiatric Unit, MDH 24. Crisis Intervention Unit, MDH 25. Psychiatric Outpatients, MDH
17th July 2014	26. Roaming Team, Mosta Health Clinic 27. Mtarfa Health Clinic 28. Male Intellectual Disability Unit
21st July 2014	29. Child Guidance Clinic, SLH 30. Outreach Team, MCH
24th July 2014	31. Paola Health Clinic 32. Paola Day Centre 33. Zejtun Day Centre

DATE	UNITS
31st July 2014	34. Floriana Day Centre 35. Floriana Health Clinic
4th August 2014	36. Young People's Unit 37. Male Ward 3A 38. Female Drug Dependency Unit
7th August 2014	39. Customer Care Department, MCH 40. Female Ward 1
11th August 2014	41. Female Ward 3B 42. Female Ward 3A
3rd September 2014	43. Gozo Short stay ward 44. Gozo Long Term 45. Paediatric Ward 46. Gozo Out-Patients
7th October 2014	Follow-up visit to the following units in Mount Carmel Hospital : Female Ward 7, Female Ward 2, Female Ward 1, Mixed Admission Ward, Pharmacy, Secure Unit (MW1), Physiotherapy Department,

ANNEX 2

Visits & Inspections Mental Health Facilities

Name of ward/unit	
Date of visit	
Start time of visit	
End-time of visit	
Consultant/s or Firm/s covering patients on ward/unit ***(from nurse/person in charge)***	
Category of ward/unit (eg acute, chronic, medical, etc) **(from nurse/person in charge)**	

1. MEET THE NURSE/PERSON IN CHARGE & ASK ABOUT:

A. STAFFING LEVELS & DEPLOYMENT:

Name & Surname of nurse/person in charge of ward/unit at this particular moment		
Grade or position of nurse/person in charge of ward/unit at this particular moment		
Current **staff** complement (at this moment in time physically **on the ward/unit**) ***(Insert numbers near each)***	Charge nurses	
	Deputy charge nurses	
	Staff nurses	
	Enrolled nurses	
	Health Assistants	
	Cleaners	
How are the **staff** deployed on the ward/unit at this particular moment: (***general description – according to what nurse in charge tells you***)		
Current **staff** complement (at this moment in time **not physically on the ward/unit**)	Charge nurses	
	Deputy charge nurses	
	Staff nurses	
	Enrolled nurses	
	Health Assistants	
	Cleaners	
How are the staff deployed outside the ward/unit at this particular moment ***(general description - according to what nurse in charge tells you)***		

B. PATIENTS

Total number of **beds** available on the ward/unit		
Does the ward include a seclusion/time out room?		
How many **patients** are (at this moment in time) **inside** the ward ***(insert total)***:		
How many patients are (at this moment in time) **outside the ward** on/in/at:	Day leave	
	Long leave	
	Main garden	
	Occupational therapy (doing what?)	

	Somewhere else (what & doing what?)	
	Seclusion	

C. ACCESS TO SPECIFIC FACILITIES

Does the ward/unit lead to a garden, yard, or other **outside space**? ***(if yes, state what)***		
Do all patients make use of this facility and how frequently ***(give some detail)***		
Do patients have access to exercise, leisure activities, and hobbies? ***(if yes, give some detail & state whether this applies to all or only a few patients)***		
Do patients have access to the following means of communication at **ward level**: ***(state yes or no),***	Television	
	Telephone	
	Computer	
	Visiting by relatives/friends	
(If yes, give some detail & state whether this applies to all or only a few patients; if no state the reasons why)		
Are patients allowed to use the following **personal means** of communication:	personal mobile phone	
	personal computer/laptop/ipad	
(If yes, give some detail & state whether this applies to all or only a few patients; if no state the reasons why)		

2. OBSERVE:

A. STAFF

What are the various staff members (mentioned above) and others who are on the ward doing at the moment: ***(against each box on the right, try to put in some detail eg 2 doctors and a nurse doing a ward round, 1 nurse doing paperwork in office, 1 nurse preparing medication in treatment room, one health assistant actively watching patients, 1 nurse sitting down evidently chatting to a friend, 1 cleaner asleep on an armchair, etc....)***	Actively engaged with patients (examining, treating, nursing, listening to, talking to, etc)	
	Actively doing paperwork or preparing treatment, or carrying out specific functions	
	Actively watching patients (overlooking)	
	Inactively sitting down/walking about	
	On the telephone/mobile	
	Lying down/asleep	
Comment on the state of uniforms and general smartness of staff eg: Doctors Nurses Health Assistants Cleaners Others: (Psychologist, social worker, occupational therapist, physiotherapist, etc)		
Comment on how the various staff speak and engage with patients		

B. PATIENTS

How many patients can you see on the ward? ***(state numbers against each of the categories)***	Common area (lounge/dining room/activity room)	
	Sleeping area	
	Smoking room	
	Treatment room/Doctor's office	
	Nursing office/station	
	Bathroom/Toilet	
	Corridor	
	Garden/yard/outside space	
	Area where visitors are received	
	Seclusion / time-out room	
	Other (please state)	
What are patients doing at the moment? Comment on the level of their engagement in activities		
Comment on the state of dress, upkeep and grooming of the patients		
Comment on any restraints applied to patients at this moment in time (eg bound to chair, etc)		

C. GENERAL PHYSICAL ENVIRONMENT:

Is the general environment welcoming? ***(state yes or no)***	
Is it bright, airy, & spacy or dull and confined? **(elaborate)**	
Is it clean and to what extent? ***(Excellent, very good, good, satisfactory, poor)***	
Are there any offensive or irritating smells? ***(State if yes or no & elaborate as necessary)***	
Is it safe without being overly restrictive? **(elaborate if necessary)**	
Is there a television on the ward which appears to be accessible to patients?	
Is there a radio or other source of music which appears to be accessible to patients?	
Is there a telephone on the ward which appears accessible to patients?	
Is there a computer on the ward which appears to be accessible to patients?	
Does the environment provide for any particular activities? ***(for example is there evidence of access to exercise and leisure activities, including hobbies on the ward/unit?)*** (Comment)	

D. ASSESS IN TERMS OF SAFETY, HYGIENE, ACCESSIBILITY, COMFORT/DIGNITY & PRIVACY & RATE ON THE FOLLOWING SCALE:

1 - EXCELLENT
2 - VERY GOOD
3 - GOOD
4 - SATISFACTORY
5 - POOR

	Safety	**Hygiene**	**Accessibility**	**Comfort and Dignity**	**Privacy**
Sleeping areas ***(in relation also to the number of beds & possibly age, sex & case-mix as relevant)***					
Lounge facilities					
Dining room facilities					
Pantry					
Smoking area					
Areas where they receive visitors					
Bathrooms & toilets					
Visiting areas					
Immediate outside space ***(state whether garden, yard, etc)***					
Activity area					
Seclusion / time-out room					

3. INSPECT DOCUMENTATION on a random sample of 3 patients who shall remain ANONYMOUS.

1. Ask the nurse/person in charge to provide you with a list of patients on the day.

2. Identify 3 patients randomly.

3. Ask the nurse/person in charge to provide you with the medical files for these 3 patients.

4. Carry out the following assessment for each of these 3 patients.

PATIENT 1

1. When was the last medical entry made in the clinical notes section? ***(give the date: DD/MM/YY)***		
2. When was the last nursing entry made in the nursing report section? ***(give the date: DD/MM/YY)***		
3a. Inspect the current treatment record/chart. Are the relevant particulars (Surname, name, ID number, month, year, ward and consultant) clearly entered?		
3b. Inspect the current treatment record/chart. Are the current regular prescriptions well charted in terms of date, route, signature and frequency? ***(you only have to check that there are entries in the appropriate boxes AND NOT the contents therein)***		
3c. Inspect the current treatment record/chart. Do the signatures indicating administration of treatment correspond appropriately up to the date and time of the inspection? **(check against the date on the treatment chart)**		
4a. Can you easily identify whether the patient's current status is that of a voluntary or an involuntary patient? ***(Do not spend more than a few minutes for this – you may consider to ask the nurse/person in charge to find this for you)***		
4b. In case of an identifiable involuntary admission, can you easily identify: ***(please give the type and date of expiry if these are easily identified)***	The type (eg Treatment Order, Continuing Detention Order, etc)	
	Date of Expiry of such Order	
5a. Is the patient's responsible carer identifiable? ***(yes, no, or elaborate if necessary)***		
5b. Is there an indication that the responsible carer has been chosen by the patient ***(yes, no, or elaborate if necessary)***		

6. Is there an adequately filled in consent to treatment form? ***(yes, no, or elaborate if necessary)***		
7. Is there documented input by: (State if yes, or no, against each)	Psychologist	
	Social Worker	
	Occupational Therapist	
	Physiotherapist	
	Other Professional/s (please state)	
8. Is there evidence of a comprehensive multidisciplinary report/plan/ or summary? ***(Elaborate or comment as appropriate)***		

PATIENT 2

1. When was the last medical entry made in the clinical notes section? ***(give the date: DD/MM/YY)***		
2. When was the last nursing entry made in the nursing report section? ***(give the date: DD/MM/YY)***		
3a. Inspect the current treatment record/chart. Are the relevant particulars (Surname, name, ID number, month, year, ward and consultant) clearly entered?		
3b. Inspect the current treatment record/chart. Are the current regular prescriptions well charted in terms of date, route, signature and frequency? ***(you only have to check that there are entries in the appropriate boxes AND NOT the contents therein)***		
3c. Inspect the current treatment record/chart. Do the signatures indicating administration of treatment correspond appropriately up to the date and time of the inspection? **(check against the date on the treatment chart)**		
4a. Can you easily identify whether the patient's current status is that of a voluntary or an involuntary patient? ***(Do not spend more than a few minutes for this – you may consider to ask the nurse/person in charge to find this for you)***		
4b. In case of an identifiable involuntary admission, can you easily identify: ***(please give the type and date of expiry if these are easily identified)***	The type (eg Treatment Order, Continuing Detention Order, etc)	
	Date of Expiry of such Order	

5a. Is the patient's responsible carer identifiable? ***(yes, no, or elaborate if necessary)***		
5b. Is there an indication that the responsible carer has been chosen by the patient ***(yes, no, or elaborate if necessary)***		
6. Is there an adequately filled in consent to treatment form? ***(yes, no, or elaborate if necessary)***		
7. Is there documented input by: (State if yes, or no, against each)	Psychologist	
	Social Worker	
	Occupational Therapist	
	Physiotherapist	
	Other Professional/s (please state)	
8. Is there evidence of a comprehensive multidisciplinary report/plan/ or summary? ***(Elaborate or comment as appropriate)***		

PATIENT 3

1. When was the last medical entry made in the clinical notes section? ***(give the date: DD/MM/YY)***	
2. When was the last nursing entry made in the nursing report section? ***(give the date: DD/MM/YY)***	
3a. Inspect the current treatment record/chart. Are the relevant particulars (Surname, name, ID number, month, year, ward and consultant) clearly entered?	
3b. Inspect the current treatment record/chart. Are the current regular prescriptions well charted in terms of date, route, signature and frequency? ***(you only have to check that there are entries in the appropriate boxes AND NOT the contents therein)***	
3c. Inspect the current treatment record/chart. Do the signatures indicating administration of treatment correspond appropriately up to the date and time of the inspection? **(check against the date on the treatment chart)**	
4a. Can you easily identify whether the patient's current status is that of a voluntary or an involuntary patient? ***(Do not spend more than a few minutes for this – you may consider to ask the nurse/person in charge to find this for you)***	

4b. In case of an identifiable involuntary admission, can you easily identify: ***(please give the type and date of expiry if these are easily identified)***	The type (eg Treatment Order, Continuing Detention Order, etc)	
	Date of Expiry of such Order	
5a. Is the patient's responsible carer identifiable? ***(yes, no, or elaborate if necessary)***		
5b. Is there an indication that the responsible carer has been chosen by the patient ***(yes, no, or elaborate if necessary)***		
6. Is there an adequately filled in consent to treatment form? ***(yes, no, or elaborate if necessary)***		
7. Is there documented input by: (State if yes, or no, against each)	Psychologist	
	Social Worker	
	Occupational Therapist	
	Physiotherapist	
	Other Professional/s (please state)	
8. Is there evidence of a comprehensive multidisciplinary report/plan/ or summary? ***(Elaborate or comment as appropriate)***		

4. INTERVIEW PATIENT/CLIENT on a random sample of 1 patient who shall remain ANONYMOUS.

1. Ask the nurse/person in charge to provide you with a list of patients on the day.

2. Identify 1 patient randomly.

3. Ask the patient whether he/she wishes to discuss care with the Commissioner.

4. Go to a second patient if first patient refuses.

5. Carry out the following assessment in private:

1. When was the last medical examination made? ***(give the date: DD/MM/YY)***	
2. When was the last nursing intervention made? ***(give the date: DD/MM/YY)***	
3. Awareness of treatment being administered? ***(yes, no, or elaborate if necessary)***	
4. Consulted about treatment and care plans? ***(yes, no, or elaborate if necessary)***	
5. Asked to fill in consent to treatment form? ***(yes, no, or elaborate if necessary)***	
6. Is patient aware whether he/she is a voluntary or an involuntary patient? ***(yes, no, or elaborate if necessary)***	
7. Has the patient's identified a responsible carer? ***(yes, no, or elaborate if necessary)***	

8. Is there other professional that he/she relates to: ***(State if yes, or no, against each)***	Psychologist	
	Social Worker	
	Occupational Therapist	
	Physiotherapist	
	Other Professional/s (please state)	
9. Tell me about the ward environment?		
10. Tell me about staff on ward?		
11. Is the ward clean?		
12. Tell me about meals, snacks, food, drink?		
13. Do you feel safe?		
14. Do you have access to a television on the ward?		
15. Do you have access to a a radio or other source of music on the ward?		
16. Is there a telephone on the ward which you can use?		
17. Is there a computer on the ward which you can use?		
18. Can you use your own mobile phone, laptop, tablet, etc.?		
19. Do you participate in any particular activities: exercise and leisure activities, including hobbies?		
20. What are your views about the future once you are discharged from here?		
21. Is there anything else you wish to tell us?		

APPENDIX 4

MALTA

IT-TNAX-IL PARLAMENT

KUMITAT PERMANENTI DWAR IS-SAĦĦA

Laqgħa Nru. 4

It-Tlieta, 8 ta’ Lulju, 2014

Il-Kumitat iltaqa' fil-Palazz, il-Belt Valletta, fis-7:00p.m.

TALBA

IS-SITWAZZJONI TAL-FAĊILITAJIET TAL-KURA TAS-SAĦĦA MENTALI GĦAT-TFAL

THE CHAIRMAN:

OMISSIS (16-il paġna)

Issa nistieden lil Dr John Cachia, Kummissarju għas-Saħħa Mentali u l-Anzjani u Dr Miriam Camilleri tista' takkumpanjah għax qegħda fl-istess team u hija ċ-*Chairperson* tal-*Public Health Medicine.*

Dr Cachia jien segwejt ħafna *lectures* tiegħek u dejjem kienu tajbin ħafna. Tista' tgħidilna daqsxejn - m'għandix dubju li inti dejjem tkun iċċarġjat b'ħafna informazzjoni u taf l-affarijiet sew - xi ħaġa dwar is-sitwazzjoni tal-faċilitajiet tal-kura tas-saħħa mentali tat-tfal?

DR JOHN CACHIA (Kummissarju għas-Saħħa Mentali u l-Anzjani): Nirringrazzjakom ta' din l-opportunità. Ħalli nibda mit-titlu. Għaliex it-titlu huwa "Is-sitwazzjoni fil-faċilità ta' kura tas-saħħa mentali għat-tfal". Però, naħseb li jekk ma naqbdux dan is-suġġett u niftħuh mill-ewwel, u nammettu li l-kura klinika hija biss *the tip of the iceberg* - il-quċċata ta' *iceberg* - m'aħniex qed naqbdu l-barri minn qrunu fis-sitwazzjoni li qegħdin nittekkiljaw. Din hija sitwazzjoni li qed iġġib fuq is-sistema, il-pajjiż u dak li qed jiġri fil-pajjiż. Dak li għandek fl-YPU, huwa rifless ta' x'qed jiġri fis-soċjetà Maltija. U għalfejn qed ngħid dan.

Għaliex jekk wieħed iħares lejn l-istejjer individwali ta' dawn it-tfal - kif jien għandi vizzju nagħmel - u tibda tara minn xiex għaddew dawn it-tfal li jiġu bżonn dawn it-tip ta' servizzi, tibda tinduna - u qed nieħu gost li hawn iċ-*Chairperson* tas-*Social Affairs Committee* għaliex naħseb li rridu nitkellmu *very straight forward* fuq dawn it-tip ta' *issues* - x'qed jiġri fil-familji tagħna, x'qed jiġri fis-sitwazzjoni tad-droga, tal-vjolenza domestika, ta' vjolenza fuq in-nies, ta' vjolenza fuq it-tfal, ta' prostituzzjoni ta' tfal, il-logħob tal-azzard, ix-xorb, l-alkoħol, l-użura. Dak kollu mill-qasam soċjali, *the social fabric*.

Imbagħad immur fuq il-qasam edukattiv u nara x'qed jiġri fuq l-*early school leavers*, tfal li ma jispiċċawx l-iskola, tfal li dejjem barra mill-klassi, il-*bullying*, is-*cyber bullying*, it-tfal li jispiċċaw bla ħiliet fit-tarf tas-sistema edukattiva. U ovvjament meta imbagħad wieħed ikabbar kemm kemm waħda x-xefaq u jmur mit-tfal għal *youths* u *young adults*, jibda jinduna li l-Faċilitajiet Korrettivi ta' Kordin jibdew jimtlew b'dawn it-tip ta' sitwazzjonijiet, biex ma nsemmix l-*unemployment* u l-*under employment* jew in-*no employment*. U d-droga, kriminalità, eċċ.

Jekk wieħed iħares lejn il-qafas ta' fuq xiex qed nitkellmu dwaru, il-YPU waħdu, jekk niżolawh u niffokaw fuqu biss, naħseb li nkunu qegħdin nagħmlu żball tattiku serju ħafna. U dan huwa l-appell tiegħi lilkom bħala l-membri parlamentari, li din trid tkun *a holistic approach from a society point of view*, biż-żewġ naħat qegħdin naqblu li aħna l-professjonisti, intom *at the political end*, jiġri x'jiġri *at the political divide* f'din it-tip ta' sitwazzjoni, irridu nkunu flimkien.

Jien jiġifieri nieħu tliet eżempji żgħar ta' *outcomes*, li wieħed iħares lejn din it-tip ta' sitwazzjoni. Dik il-persuna ta' 25 sena li f'10 snin ħadmet 3 ijiem. Nieħu l-eżempju ta' persuna ta' 14-il sena li ila ma tmur skola sentejn. Nieħu żagħżugħ ta' 14 jew 16-il sena, li meta tgħidlu fejn joqgħod, jgħidlek li m'għandux indirizz, u ma jridx imur lura lejn id-dar ta' ommu u missieru.

ONOR CHRISTOPHER FEARNE: Dawn ma messhomx ikunu fi sptar mentali!

DR JOHN CACHIA: Eżattament. Imma dan hu li qed niddiljaw bih. Dawn huma eżempji li jien ltqajt magħhom f'dawn l-aħħar ġimgħat. Li huwa ovvju li mhux posthom ġo sptar mentali dawn. Imma s-saqaf, il-platt sħun, is-sodda, l-akkoljenza ta' dawn hija biss .... U hawn fejn jien ningħaqad miegħek, Mr Chairman, u naħseb l-Onor Fearne u ċert min-naħa tal-Oppożizzjoni wkoll, li nirringrazzja lin-nies li jaħdmu ma' dawn in-nies, talli kuljum lil dawn in-nies joffrulhom platt sħun u sodda, u saqaf. U nirrepeti x'tħobb tgħid id-Dottoressa ta' maġenbi, li jagħtuhom l-imħabba li jista' jkun li qatt ma sabu f'ħajjithom dawn it-tfal u ż-żgħażagħ.

U naħseb illi jekk nibdew minn dan il-lat uman, għax dawn Maltin, la barranin, la refuġjati, la *asylum seekers*, dawn Maltin. Setgħu kienu. Imma dawn Maltin bħalna, fis-soċjetà Maltija, dawn prodott tas-soċjetà tagħna. Allura dawn in-nies, mitlufin fis-soċjetà. Jien meta xi ħadd jispiċċa fuq il-media fuq kriminalità jew għax ġara xi ħaġa l-YPU, naħseb li nkunu qegħdin nagħmlu disservizz lilna nfusna, jekk naħsbu li se nittekkiljaw din s-sitwazzjoni b'dan il-mod.

U allura meta jien nitkellem b'dan il-mod, f'isem dawn il-persuni, nipprova nkun il-vuċi ta' dawn il-persuni - kif fid-dover li nkun permezz tal-liġi - u ngħid li l-YPU ma jistax jibqa' jakkomoda ukoll il-problemi li għandna hemm ta' *conduct disorder*, ta' *social problems*, ta' *challenging behaviour*. Ma smajtx li hemm *autistic spectrum disorders*! Ma nafx għadx fadal, jidhirli għad fadal ukoll. Jekk ma fadalx, *God Bless*, almenu naqqas *one issue*. (Interuzzjonijiet) Għax kiber jew qasam it-triq.

Ejja nkunu ċari fuqhiex qegħdin nitkellmu. Din il-ħallata ballata ma tagħmel ġid lil ħadd, l-inqas lil dawn it-tfal. Persuna b'*acute psychosis who is disrupting the situation*, bniedem li għandu *behavioral problems* mhux qed tagħmillu ġid.

It-tieni punt huwa li ġol-YPU nnifsu, kif diġà ntqal, m'hemmx faċilità approprijata fejn inti tista' *de escalate safely* żagħżugħ li għandu *behaviour* vjolenti jew *behaviour* aggressiva. Għaliex l-ispazju huwa meħud b'nies li m'għandhomx ikunu hemm, imma għandhom ikunu x'imkien ieħor.

Issa ngħid x'naħseb li għandu jiġri. Jien allura, bħala Kummissarju, filwaqt li jien kontra li jkun hemm tfal jew żgħażagħ fil-*wards* tal-adulti, ikolli ngħid li minħabba s-sitwazzjoni kif żviluppat u evolvit - mhux illum u 'lbieraħ ta', imma *over the last few years* - hemm bżonn li jekk ikollna bżonn inpoġġu żagħżugħ, tifel fil-*ward* tal-adulti biex nipproteġu lilu u lill-oħrajn, dan irid ikun għall-inqas żmien possibbli, bil-protezzjoni kollha possibbli ġo dak il-*ward* u wkoll li l-*multi disciplinary assessments* – u din għamilt enfasi ħafna fuqha riċentement ukoll fl-aħħar episodju li kellna – iridu ikunu iktar spiss u regolari.

Naf li qed isir. Kont preżenti meta kien qed isir, u rajt *issues* qed jiġu *tackled*. U l-*management* ikollu *pro-active approach* biex jagħfas fuq din it-tip ta' sitwazzjoni. Però jekk m'aħniex se ngħinnu biex *we defunction* minn dak li m'għandniex bżonn u m'għandniex meħtieġ, iridu nagħtu *options* oħra. U x'inhuma l-*options*?

Nemmen, kif tkellmu hawnhekk, bil-kwestjoni tal-*acute psychosis*. Hawnhekk jien se nkun ftit iktar provokattiv f'isem dawn in-nies, u nemmen li *an acute psychiatric situation should probably be best dealt with* - fiċ-ċirkostanzi ta' Malta llum - *in an acute hospital*. Jien nemmen li wasal iż-żmien li nieħdu *a bold step* u ngħidu *acute pediatric hospital* - ħalli nibdew minn tfal u adolexxenti - an *acute episode of psychosis in a child, in an adoloscent* u jista' jkun li wasal iż-żmien li

nagħmlu riflessjoni u ngħidu: isma' wasal iż-żmien li nieħdu dawn il-*bold steps*.

Jien il-psikjatrija akuta ġo sptar ġenerali, esperjenzajtha fl-1980, meta jien bħala student tal-mediċina mort Glasgow, u dak iż-żmien diġà kellhom *an acute psychiatry in a general hospital environment*. Ikun hemm *ward*, bħalma għandna l-*psychiatric unit* . (Interuzzjoni)

Jiddispjaċini - ħalli nkun ċar u skjett - imma trid tiffunzjona kif suppost bħala *acute psychiatric service*. Issa jekk għandniex nibdew bit-tfal, issa wieħed irid jara ftit. Naf li hemm min ma jaqbilx miegħi fuq dan is-suġġett, però jien ngħid, wasal iż-żmien li nagħmlu din it-tip ta' riflessjoni f'dan il-pajjiż?

THE CHAIRMAN: U l-idea hi għat-tfal jew għall-kbar?

DR JOHN CACHIA: Eventwalment nibdew bit-tfal. Però jien ngħid li wasal iż-żmien għax meta tissiftja u tara x'qed jiġri fil-psikjatrija, huma numri żgħar li jkollhom *acute psychiatric issues*. L-episodji ta' *acute psychiatry* li għandhom bżonn *intensive attention,* jiġifieri li għandu bżonn MRI, CT Scan u testijiet mediċi u eċċ ..... Importanti li wieħed jibda ....

ONOR. MICHAEL GONZI: Inti qed tissuġerixxi li jkun hemm *an acute psychiatric unit* barra Mount Carmel, jiġifieri jkun Mater Dei. Għaliex? (Interruzzjonijiet)

DR JOHN CACHIA: Fil-*ward* tat-tfal ikun hemm kamra armata għal dawn it-tip ta' tfal. Ikollok in-nies imħarrġa li jkunu kapaċi jagħmlu *an acute psychiatric service.*

ONOR. MICHAEL GONZI: Imma jekk għandek in-nies ittrenjati fl-*acute psychiatry* f'Mount Carmel?

DR JOHN CACHIA: Jekk inti qed titkellem fuq *acute psychiatry* tat-tfal, *acute psychiatry* tat-tfal hija speċjalità *on its own*. Għandi espert fil-pedjatrija quddiemi...

ONOR. MICHAEL GONZI: Ma nistax nimmaġina li jkollu *ward* hemmhekk ...

DR JOHN CACHIA: *We are not talking big numbers fuq it-tfal*. Ma nazzardax ngħid in-numri, però way back kellna *projections* ta' *4 to 8 beds, maximum*. Il-*projections* l-antiki, meta kien hemm din l-idea ta' *neuro psychiatric interventions*.

Ifhimni, Onor Gonzi, *it is open for discussion*. Ejja npoġġuha fuq il-mejda bħala *option*, m'għandix diffikultà jien. Innaqqsu l-istigma, intajru ċertu affarijiet min-nofs, nagħmlu ċertu *issues* ta' integrazzjoni tal-psikjatrija *in mainstream medicine* ukoll. Għax naħseb li wasal iż-żmien li nitkellmu b'dawn it-tip ta' provokazzjoni kważi.

Imbagħad għandna bżonn it-tieni fażi. Dak li qed jiġri llum ġewwa l-YPU. Jiġifieri rridu naraw ir-riabilitazzjoni. Ir-riabilitazzjoni attiva, li tieħu ħsieb li dawn it-tfal *with challenging behaviour*.

U r-*revolving door approach*, pereżempju, hemm Fejda, hemm St Joan Antide u s-servizzi tal-aġenziji Support u Appoġġ, li jagħtu dan it-tip ta' servizz fil-komunità lit-tfajliet. Imma pereżempju m'hemmx biżżejjed għall-*boys* f'dawn it-tip ta' sitwazzjonijiet. Trid tara r-*revolving door situation,* fejn dawn it-tfal b'*challenging behaviour* li għandhom bżonn riabilitazzjoni attiva, ma jibqgħux f'dak l-ambjent.

It-tielet hija l-kwestjoni ta' transizzjoni. *Out of home living* għal dawk it-tfal li ma jridux imorru lura d-dar, għax d-dar tivvelinalhom il-ħajjithom. Iġġibhom agħar minn dak li huma. U hemmhekk naħseb li naqblu żgur, li l-kwestjoni ta' *life*

skills, kwestjoni ta' edukazzjoni, kwestjoni ta' *employability at a join up approach at a social, health, education, employment, and security level. Whoever needs to be there, should be there*.

ONOR. DEBORAH SCHEMBRI: Qed titkellem fuq tfal li ma jixtiequx imorru lura d-dar għaliex hemm sitwazzjoni li mhijiex tajba d-dar. *Which to me means* li għandek tfal li għandhom bżonn *protection* u allura għandhom bżonn *care order*. Għax *care order* għandek *care, protection or control*.

Li tinkwetani li mbagħad issib li min qiegħed b*'care order*, u qiegħed jiġi jerġa' mpoġġi f'Mount Carmel.

DR JOHN CACHIA: Hekk hu.

ONOR. DEBORAH SCHEMBRI: U dak qed idum iktar, bħala żmien, minn nies oħrajn. *It is a vicious circle*. Dawn, *in the first place,* mhux suppost qegħdin hemmhekk, però jekk se nibagħtuhom fejn suppost, imbagħad minn hemm, qed jerġgħu jibgħatuhom ukoll Mount Carmel. Jiġifieri hemm *mumble jumble* sħiħa.

DR JOHN CACHIA: Eżatt. Is-sitwazzjoni hija li inti għandek ċertu affarijiet li żviluppaw b'tali mod *in a social environment*. Miniex kompetenti biex nitkellem fuq dak l-att soċjali, però forsi jkun hemm ħaddieħor jifhem iktar minni. Però nemmen li fl-*issues* soċjali hawnhekk, qed niddiljaw mal-popolazzjoni l-iktar vulnerabbli ta' din is-soċjetà. Naħseb li jkollok risposta mingħand persuna ta' 19-il sena li qattgħet kważi nofs għomorha ġewwa Mount Carmel, li tgħidlek jien irrid ngħix fuq ir-*relief*. Tfajla ta' 19-il sena! Din it-tip ta' deċiżjoni li hija *issue* oħra, li wieħed irid jibda jħares lejha.

Irrid ngħid ħaġa oħra. 'Ilbieraħ filgħaxija kien hemm il-BBQ tal-festa tal-Madonna tal-Karmnu. U dawn it-tfal li qed nitkellmu fuqhom, tal-YPU, kienu hemm, *enjoying themselves* daqslikieku kienu t-tfal tiegħi u tiegħek. Dawn iż-żgħażagħ li qed nitkellmu dwarhom, kienu hemm, *enjoying themselves*, qishom parti mill-komunità. Ejja ma noqogħdux niddemonizzaw is-sitwazzjoni. Ejja nkunu saqajna mal-art. Naraw dawn iż-żgħażagħ, dawn it-tfal x'għandhom bżonn, naraw l-*iskills* u l-opportunitajiet li tilfu. Jiena dejjem hekk ngħid, li kieku dawk kienu t-tfal tiegħi li għaddew minn dak li għaddew dawk it-tfal, jista' jkun li forsi jagħmlu agħar minnhom.

THE CHAIRMAN: Dr Cachia jekk ikollok pazjent li qiegħed il-YPU, u skont il-psikjatri u t-tobba jista' jiġi *discharged*. U fejn se jiġi *discharged*, jekk id-dar fejn irid imur hija disturbata, forsi *single mother*, forsi tieħu d-droga, dak x'jiġri mill-każ imbagħad?

DR JOHN CACHIA: Hemmhekk insellem ħafna lin-nies li jaħdmu fil-qasam soċjali għaliex qabel ma jkun hemm *a safe environment* fejn dak it-tifel jew żagħżugħ jista' jmur, dak it-tifel jinżamm. Din hi l-problema. Il-problema hija l-iżbokk. Dejjem is-sitwazzjoni hija l-iżbokk tajjeb, biex dawn it-tfal u żgħażagħ jingħataw dak li għandhom bżonn.

THE CHAIRMAN: Imma minbarra l-YPU, m'hemmx pereżempju post ieħor?

DR JOHN CACHIA: Le. It-tfajliet għandhom pereżempju Fejda, St Joan Antide. Imma dawn uħud minnhom, bħal ta' St Joan Antide ma jifilħux għalihom,

THE CHAIRMAN:L-NGOs m'għandhomx djar?

DR JOHN CACHIA: St Joan Antide huwa parti minn Sapport. Ħalli npoġġiha ċara. Hemm is-sorijiet li kienu jieħdu ħsieb dawn it-tfal meta kienu ħafna iktar żgħar. Imma hemm uħud mit-tfajliet li meta kibru, saru iktar *challenging*, u

għandek *issues* fejn għandek diffikulta fejn se tieħu ħsiebhom. U *this is the issue that society needs to look into.*

ONOR. MICHAEL GONZI: It-tfal li jkunu l-YPU, kif jgħadduha l-ġurnata.

DR JOHN CACHIA: Jien li nista' ngħid huwa dan. Hemm diversi sitwazzjonijiet li rajt b'għajnejja. Jien nista' ngħid dak li rajt b'għajnejja, jien noqgħod ħafna fuq dak li nara b'għajnejja. Nisma', għidli li trid, però mbagħad immur u nara b'għajnejja.

Pereżempju, 'lbieraħ uħud minnhom rajthom fil-festa tal-Madonna tal-Karmnu. Uħud minnhom naf li jmorru l-iskola. Kont l-*occupational therapy*, u kienu qegħdin hemm, jagħmlu, jagħtu sehemhom, u jippreparaw il-*mementos* - għax għandhom konferenza ġejja - u jwaħħlu u jagħmlu.

Però naħseb il-kwestjoni kollha hija programmi ta' iktar intensità biex dawn it-tfal, joħorġu l-ħiliet u l-*iskills* tagħhom. Jiena nemmen bil-ħiliet, *skills* u *employability*.

ONOR. MICHAEL GONZI: Faċli ngħiduhom dawn. Imma ma' dawn it-tfal, dawn il-ħiliet, l-*iskills*, dawn qed jiġu *tackled* ma' dawn it-tfal?

DR JOHN CACHIA: Għandna bżonn iżjed, *definitely*.

ONOR. MICHAEL GONZI: OK għandna bżonn iżjed, imma llum x'qed nagħmlu?

DR JOHN CACHIA: *Within the resources available*, naħseb li ċertu nies qed jagħmlu l-mirakli. Anzi, jiena l-ewwel wieħed li ngħidlek li *within the resources available* qed isiru l-mirakli, però f'ċertu *areas, we are beyond miracles*. Hemm bżonn li ċertu *issues* jiġu *tackled*. L-iżbokk - nerġa' nirrepeti - ta' dawn iż-żgħażagħ biex ikollhom *a safe environment* fejn ikunu, ma nistgħux naħarbu minnha. *If we are not going to provide it*, inutli tipprova tagħtihom l-*iskills*.

ONOR. MICHAEL GONZI: Jekk dawn imbagħad jiġu integrati mal-familja - *hopefully* - hemm riżorsi biex dawn jiġu *followed* imbagħad fil-komunità, biex l-affarijiet ma jerġgħux jiggravaw? Speċjalment ikollok tfal li jagħmlu *self harm* jew li jkunu *aggressive*. Imma tista' ma tkunx fil-familja, jista' jkun *bullying* fl-iskola.

DR JOHN CACHIA: Fil-fatt il-liġi dwar is-Saħħa Mentali, tersaq lejn dak is-suġġett mill-punto di vista ta' *responsible carer*. Tgħidli mhux kollha għandhom il-ġenituri dawn. Imma jista' jkun hemm sitwazzjonijiet fejn il-ġenituri *is not the best person to be the responsable carer* ta' dak iż-żagħżugħ. Bil-mod il-mod, wieħed irid jibda jevolvi dak il-kunċett mil-liġi tas-Saħħa Mentali, biex wieħed jara *in the best interest* ta' dawn iż-żgħażagħ, pereżempju, min hu l-aħjar *responsible carer* għalihom.

Eventwalment wieħed irid jiddiskutiha wkoll fuq livell soċjali u naraw naqra kif se taħdem il-liġi tal-*Guardianship*, u kemm se nkunu nistgħu ngħinu lil dawn iż-żgħażagħ b'*guardianship, once* li jkunu għalqu t-18-il sena. Għax inutli nagħmlu l-*care orders,* biex imbagħad kif jagħlqu t-18-il sena, nagħlqu l-*file* u l-problema qisha spiċċat.

Inbidlet diġà l-kwestjoni tal-*guardianship*. Il-kwestjoni li tinkwetani jien hija din, dik li tifla jew tifel li qed jiġi segwit mill-YPU, Appoġġ, eċċ kif jagħlaq it-18-il sena nagħlqu l-file u nitfgħuh fil-qiegħ, biex naraw *the next problem*. Dan it-tifel għadu bil-problemi meta għalaq it-18 jew id-19-il sena u hemmhekk, f'dak l-*interphase*, f'dik it-*transition*, irridu nieħdu ħsiebha sew, it-*transition to adulthood*, għax

imbagħad hemmhekk fejn jispiċċaw bil-kwestjonijiet ta' kriminalità, ħabs, eċċ.

ONOR. CLAUDIO GRECH: Speċifikatament fuq il-faċilitaijiet li għandna llum, biex jilqgħu lit-tfal ġo fihom, dawn illum huma konformi mal-provvediment tal-leġislazzjoni? U mil-lat tiegħek, x'qiegħed isir biex forsi nkunu nistgħu nagħmlu dan l-*alignment*?

Jien l-Uffiċċju tiegħek narah mhux biss bħala *a watchdog,* però wkoll dan l-aħħar anke ħadt iktar ir-*role* li taħdem għal *alignment*; li hemm ċertu *bars* ta' kwalità, li idealment *we not just tick the boxes but you assist the care providers to reach that bar,* biex imbagħad flimkien ngħolluh daqsxejn oħra dak il-*bar*. Dak finalment l-*outcome* li qed infittxu. Għax jien naqbel perfettament kif bdejt inti, *that we have to look holistically, eċċ, but we are into lay session focusing on something very very specific* bil-limitazzjonijiet kollha tal-ħin li għandna. *So*, minn dak li assessjajt s'issa - għax inti wieħed mill-iktar li tista' tassessja għax *you touch first hand on a day to day basis - are they in line with legislation* b'mod partikolari mal-aspett ta' liċenzjar? U forsi x'qed isir *vis-à-vis* l-*alignment* li hemm bżonn li jkollna?

DR JOHN CACHIA: Għar-rigward tal-liċenzjar, dak hemm is-Supretendenza tas-Saħħa Pubblika li għandha r-responsabilità li tara hi. Anke jekk id-domanda li staqsejt int fuq *standards* etc, *I will not encroach there,* dik hija responsabbilta tas-Supretendenza. Jien ir-responsabiltà tiegħi li nara, li anke s-Supretendenza tagħmel dmirha. U hemmhekk se nkun qiegħed inħares lejha wkoll.

Rigward dak li tgħid il-liġi, naħseb li jkollna *time-out room* u *de escalation facility within a YPU setup, will go a long way,* biex niffaċilitaw - almenu b'mod temporanju - is-sitwazzjoni li għandna f'idejna bħalissa. (Interuzzjoni) Hemm, imma l-kwestjoni mhix *safe* biżżejjed biex tista' żżomm persuna li għandha *disruptive behaviour* esaġerat.

Jien naħseb li l-fatt li jkollna nirrikorru għall-*wards* tal-adulti *to contain* ċertu tip ta' sitwazzjonijiet, naħseb li hija xi ħaġa li jekk nagħmlu riflessjoni interna nistgħu nippruvaw nsibu soluzzjoni għaliha din. Kif qal Dr Grech, ma tistax tagħmilha fuq, għax jekk għandek sitwazzjoni fejn bniedem iqiegħed ikun *disruptive* għall-kumplament tal-*unit*. Però nemmen li jekk nippruvaw noħolqu dan it-tip ta' ambjent, inkunu qed napproċjaw kemm kemm iżjed. Il-liġi tgħid li ma nistgħux nibqgħu f'sitwazzjoni fejn min għandu bżonn *social care*, jiġifieri saqaf, platt sħun u sodda, imma mhux kura psikjatrika, m'għandux ikun ġo sptar mentali.

THE CHAIRMAN: Din l-istess ħaġa, tapplika għal Mater Dei wkoll.

DR JOHN CACHIA: Ifhimni, din hi l-*issue* kollha. L-ewwel żewġ *issues* li rridu naġixxu fuqhom, huma dawn iż-żewġ *issues. One: a de escalation facility within a YPU setup* li jkun iktar dedikat għal dawn it-tfal meta jitgerfxu. Ħaġa temporanja għax il-pjanijiet l-oħrajn huma sbieħ ħafna u ejja nimxu lejhom.

U t-tieni waħda hija li min m'għandux problemi ta' saħħa mentali, m'għandux ikun f'ambjent li hu kopert bil-liġi tas-saħħa mentali.

THE CHAIRMAN: Nirringrazzjak Dr Cachia.

OMISSIS (11-il paġna)

THE CHAIRMAN: Nirringrazzja lill-membri kollha, bħalma nirringrazzja lill-mistiednin kollha. Naġġornaw il-laqgħa għal wara r-*recess* tas-sajf.

APPENDIX 5

Stqarrija mill-Uffiċju tal-Kummissarju għas-Saħħa Mentali u l-Anzjani rigward Bord ta' Investigazzjoni maħtur mill-Kummissarju biex jinvestiga inċident li seħħ ġewwa l-Isptar Monte Carmeli fl-20 ta' Mejju 2014.

Wara li ġie infurmat b'inċident li allegatament seħħ ġewwa l-Isptar Monte Carmeli fl-20 ta' Mejju 2014, Il-Kummissarju għas-Saħħa Mentali u l-Anzjani ħatar Bord ta' Investigazzjoni fit-22 tal-istess xahar.

Il-Bord kien inkarigat biex:

- Jistabilixxi il-fatti tal-każ billi jiġbor l-informazzjoni kollha relevanti;
- Jiddetermina jekk kienx hemm xi mankanzi fil-kura u l-attenzjoni u, jekk fl-affermattiv, jindika min kien responsabbli għal tali mankanzi;
- Jiddetermina wkoll jekk tali mankanzi jikkostitwux ksur tad-drittijiet tal-pazjent u/jew nuqqas ta' ħila professjonali;
- Jirrakkomanda kull azzjoni li għandha tittieħed u minn min, u
- Jagħmel kull rakkomandazzjoni oħra li jħoss li hija relevanti għal każ.

Il-Bord, kostitwit minn uffiċjali mill-Uffiċju tal-Kummissarju, wara li ffamiljariżża ruħu mad-dokumentazzjoni kollha li kienet disponibbli kif ukoll rapporti fil-media dwar il-każ iddeċieda li għandu jintervista numru ta' persuni konnessi mal-allegat każ, jagħmel viżta fil-post fejn ġara l-inċident u jeżamina id-dokumentazzjoni uffiċjali kollha relatata mal-każ.

Il-Bord intervista b'kollox 18-il persuna f'erba' sessjonijiet. Dawn kienu jinkludu l-allegat vittma, l-istaff inkarigat mill-ward fejn kien qed jirċievi il-kura, persuni li ġew mitluba jintervjenu wara l-inċident, social worker li ssegwi lill-pazjent, it-tobba kuranti kif ukoll l-management tal-Isptar.

Wara li kkonkluda il-fażi tal-intervisti kif ukoll l-eżami tad-dokumentazzjoni disponibbli, il-Bord wasal għal numru ta' konklużjonijiet u ssuġġerixxa wkoll numru ta' rakkommandazzjonijiet.

Il-konklużjonijiet huma elenkati kif ġej:

1. L-allegazzjoni li t-TV tas-sala kien fuq stazzjon politiku, għalkemm ma tistax tiġi ippruvata, hija ikkunsidrata bħala kredibbli u probabbli;

2. Ma nstabitx evidenza li l-allegat vittma kienet provokata u/jew mgħajjra għalkemm ma jistax jiġi eskluż xi forma ta' nbix li, meta wieħed jieħu in kunsiderazzjoni l-istat mentali tal-pazjent, seta' kkontribwixxa biex teskala s-sitwazzjoni;

3. Ghalkemm gie stabbilit li ntużat il-forza biex il-vittma tiġi kkontrollata, ma ġiet rilevata ebda evidenza li tissustanzja l-allegazzjoni li l-vittma ġiet imsawta;

4. Ġie stabbilit illi waqt il-fażi ta' kontroll tal-vittma ingħatat injezzjoni. Relatat ma dan il-fatt il-Bord irrileva numru ta' irregolaritajiet.

Konsegwentament il-Bord irrakkommanda li:

1. Jiġu stabbiliti linji gwida ċari u bil-miktub dwar l-użu tat-TV fis-swali, b'mod partikolari fejn jidħlu programmi ta'natura politika li jistgħu joħolqu diżgwid bejn il-pazjenti nfushom kif ukoll bejn il-pazjenti u l-istaff;

2. Għandu jingħata taħriġ fuq bazi regolari lill-istaff kollu f'materja bħal "*emotional intelligence*" u "*communication skills*" sabiex l-istaff isir dejjem iżjed sensittiv għall-ħtiġijiet partikolari tal-pazjenti;

3. Għalkemm jirriżulta li numru ta' staff ingħata taħriġ, fuq bażi volontarja, fid- "*de-escalation techniques*", dan it-taħriġ ma ġiex segwit mill-istaff kollu. Huwa mportanti li staff li jista' jiġi affaċjat b'dawn it-tip ta' sitwazzjonijiet jingħata it-taħriġ neċessarju biex dawn l-inċidenti jiġu riżolti b'mod li jissalvagwardja is-saħħa u s-sigurta' tal-pazjenti kif ukoll tal-istaff;

4. L-awtoritajiet kompetenti għandhom ikomplu jinvestigaw l-irregolaritajiet li ġew rilevati mill-Bord kif ukoll mill-management tal-Isptar rigward l-amministrazzjoni ta' mediċina partikolari u jittieħdu dawk il-passi kollha li jiġu meqjusa neċessarji, inkluż passi dixxiplinarji.ċġħ

Ir-rapport finali tal-Bord ġie mgħoddi lill-Ministru u s-Segretarju Parlamentari responsabbli mis-Saħħa kif ukoll lis-Segretarju Permanenti fl-istess Ministeru. Ir-rapport, li jinkludi diversi dettalji ta' natura kunfidenzjali rigward is-saħħa mentali tal-pazjent, mhux qed jiġi ppublikat.

22 ta' Lulju 2014

APPENDIX 6

Business Solutions: Any Gains for Mental Health?

Conference Report

Office of the Commissioner for Mental Health and Older Persons

20th June 2014

Business solutions: any gains for Mental Health?

A conference was organised by the Office of the Commissioner for Mental Health and Older Persons entitled ***Business solutions; any gains for Mental Health?*** The conference was held on the 10th June, 2014 at Le Meridien Hotel in St Julians. The conference was aimed at leaders within the public mental health service.

Background

The aim of the conference was to bring together experts from both the business and the health sectors to share ideas of how to provide person-centred care through the skills and expertise of a team of professionals. Offering a good quality service upholds the dignity and the rights of the recipient. The coming into force of the Mental Health Act has made us aware of the need for change as certain practices within the mental health services need to be updated to better conform to the provisions of the new legislative framework. Einstein equates insanity to doing the same things over and over again, and expecting different results, so service improvement can only be brought about through the effective implementation of change in mindset and practice. Change may pose a challenge as it may instil a sense of uncertainty. Change may be resisted by those who may not perceive the need for change, as they are convinced that the service offered is the best possible, or because change presents a departure from old ingrained practices thus leaving their comfort zone.

The new mental health act is the vehicle for change for mental health services, a tool which can transform the challenges for better care into opportunities. It is in this spirit that four pillars emanating from the mental health act were identified for discussion during this conference; namely (i) rights of users and their carers, (ii) patient-centred care, (iii) multidisciplinary collaboration and (iv) patient safety and quality of care. These topics represent the core values within the act. Healthcare outcomes will only improve if the rights of the service users are respected, if care is patient-centred, safe and of good quality and offered through a multidisciplinary approach. These objectives can only be attained if the right drivers for change are in place namely good leadership, the fostering of trust and collaboration and communication between all the stakeholders, including patients and their carers.

The conference involved the participation of the business sector in order to tap their knowledge and expertise since in general the private sector is more responsive to embrace change. Businesses are fully aware that it is only through the continuous renovation and reinvention of their product that they may remain valid contenders in a highly competitive

market. Parallels were drawn between the private sector and the four main areas from the mental health act. To this end, Dr Vanni Xuereb, head of MEUSAC, compared the rights of the EU citizen with the rights of patients and their carers, Ms Angelique Spina, senior manager in the Advisory Line of Service at Price Waterhouse Coopers Malta, discussed multidisciplinary collaboration, Mr George Micallef, a tourism consultant spoke about the person-centred approach in the tourism industry and Mr Lawrence Zammit who has widespread experience in business management, spoke about the evolution of safety and quality in industry. In their brief presentations, these contributors highlighted the manner in which these topics are tackled in their respective areas. The mental health perspective on the four pillars chosen was given by Dr John M. Cachia, the commissioner for mental health and older persons. A short opening address was delivered by the Parliamentary Secretary for Health, the honourable Chris Fearne. Mr Fearne stressed the importance of involving all the stake holders, especially the patients' family in order to provide an integrated, good quality health care. He acknowledged the need of a service which is timely and responsive to the needs of the client.

Presentations

A wind rose for mental health presented by Dr John M Cachia Commissioner for mental health and older persons. Dr Cachia drew analogies between the various characteristics of wind such as variable force, different directions and long term effects on the environment to the various forces pushing for change brought about by the implementation of the mental health act. Although the act in itself might not provide all the necessary caveats of how mental health services are to be provided, it is the driving force to bring about a change in mentality and practice to offer a safe and quality patient-centred care through multidisciplinary collaboration.

The relevance of EU Citizen's Rights to the local context was presented by Dr Vanni Xuereb. He drew parallels between the rights enjoyed by EU citizens and the rights of patients and their carers and forms of redress. He emphasised the need to communicate rights using various modalities and platforms and that safeguarding of rights must be part of daily practice.

Ms Angelique Spina's presentation on **Multi disciplinary collaboration within PwC** showed that communication is key to collaboration; to this end both horizontal and vertical consultation is necessary to ensure that all the expertise of the wide array of professionals within the firm is tapped. This wide consultation would ensure that the best advice is given to the client. For multidisciplinary collaboration to be successful good leadership and accountability of the team members are mandatory.

Mr George Micallef spoke about the **Perspective of the Tourism Industry**. He stated that the tourism industry is constantly undergoing change in order to face up to the challenges presented by the global economy, competition, technology and a better informed client having higher expectations. The industry strives to give its clients a positive experience that surpasses their expectations. This is only possible through ongoing client-based research targeted at improvement and development of its products and services to provide a good quality product.

Mr Lawrence Zammit presentation was entitled **Mental Health – any gains from business solutions?** This focused on the care and safety aspects within a business. He explained how quality targets must be embedded in all systems, measures and practices within the firm in order to satisfy customer's needs. Communication of the vision through good leadership, fostering of trust, empowerment and the effective involvement of all the employees are conducive to a motivated workforce that embraces change.

Workshops

A cabaret seating style was adopted so as to facilitate discussion among the 80 delegates on the four topics chosen. A mix of management personnel and healthcare professionals was selected for each table to foster an interactive debate between the managerial and operational arms of the mental health service. Each workshop presented a set of proposals stemming from the discussion with the aim to inform policy or practice within mental health services.

The underpinning facts that emerged from most workshops included good leadership and common goals, good communication between all stakeholders, workforce that has the required number of employees with the right skill mix, continued training and support of staff and more empowered patients and carers through better information about their rights and available services.

Rights of users and their carers

- Persons must be informed of their rights. This applies to all patients, especially to those with a mental disorder. Patients and their carers must be made aware of these rights so as to ensure that these are upheld and that due pressure is made to the relevant authorities if these rights are being overlooked.
- The healthcare workforce should be aware of the rights of the patients and also convinced about them in order to endorse them in their daily practice.
- Dissemination of patients' rights to the general public through the media and through information leaflets would increase awareness about these rights and hence their protection.

Patient-Centred Care

- Quality should be the main driver of service provision and all healthcare workers should make a concerted effort to provide a positive experience to the patient. This requires better communication and involvement of the patients and their carers in the care being offered, such as in the formulation of the care plan.
- The performance of a Patient Satisfaction Questionnaire would provide a platform wherefrom patients can provide feedback and action can be taken according to the findings.
- Information about the services offered and about the presence of a redress system would empower the patients in making them more aware of their rights.
- Quality of service is to be monitored and reviewed regularly by management, and work systems should be improved and updated so that work practices truly reflect a patient-centred care approach.
- Maintaining a high standard of care requires the continual investment in human resources through having an adequate number and skill mix, complemented with continual training and self-development of these workers.

Multi-disciplinary Collaboration

- Teams should have a shared vision and should work towards common goals.
- Good leadership instils a feeling of belonging among team members and this would motivate the team and translate into more commitment and participation on their part.
- Communication, both vertically and horizontally across the team is key to fostering team spirit and to elicit the best decisions leading to client care/needs. It is also important to keep all team members informed about decisions related to their work.
- The creation of a web forum would provide a means of interaction and sharing of information between healthcare providers. Training to be valid team members should be started at undergraduate level.
- Performance of the team is dependent on the qualities and skills of its members, and this must be taken into consideration when recruiting individuals. Management should indicate to staff members what skills need to be developed on an individual basis in order to continually satisfy the changing needs of such a service-based organisation.
- The availability of good supportive systems such as coaching and mentoring within the organisation would ensure the well being of its employees.

Quality and Safety

- Communication between all stakeholders is important to ensure continuity of care between the hospital and community interface; this especially applies to communication with patient and their responsible carers so that they can seek timely advice about patient care.

- The general practitioner is an important link between hospital and community care, however this vital link is usually lacking as patients do not always have a GP. Patient registration with a GP would be an asset to ensure continuity of care.
- Incident reporting must be encouraged, however staff needs to recognise the inherent value in reporting so as to oblige. Staff must be made aware of when and what to report.
- Management must adopt a non-blame culture and it must communicate this clearly and repeatedly to staff.
- The goal of incident reporting is systems improvement and to this end management should set up an Incident Review Team to analyse reports and come up with recommendations for quality improvement.
- All healthcare workers should be cognisant that quality is their responsibility and that a good quality service would translate into health gains.
- The choice of Key Performance Indicators (KPIs) must be adapted to the local cultural scenario and not simply be adopted from other systems. All stakeholders need to be involved in the formulation of performance indicators to ensure collaboration and cooperation.
- Good leadership is conducive to good teamwork and to the building of trust between the stakeholders. If management is supportive and shares its goals with the health workers, the latter would be more receptive to change.

Conclusion

The conference provided an opportunity for management and healthcare professionals to discuss issues of concern for them in a neutral environment. Hopefully this conference would be the instigator of a change process in both mindset and approach to patient care. There is much to be gained from putting into practice the provisions of the mental health act as it has the patients' interests at its core and provides the appropriate safeguards for the protection of patients' rights and the provision of good quality patient-centred care through multi-disciplinary collaboration. Successful business models may be adapted to achieve excellence in mental health service delivery.

Antonella Sammut
Resident Specialist in Public Health

John M Cachia
Commissioner

Evaluation

Evaluation form

Participants were asked to give feedback to assess if the seminar reached their expectations. A brief evaluation form was devised in order to obtain the following information; (i) the professional background of the participant (ii) ratings of nine seminar variables and (iii) the impact of the information obtained from the conference on the responder's daily work. Also, space was provided wherein participants were free to put down their comments. A copy of the evaluation form is annexed to this report.

Results

Professional background of participants

Out of a total of 73 registered participants, feedback was received from 53 (73%) of the attendees. These attendees were divided according to their professional background. The category named 'others' includes feedback from a pharmacist, academic, team leader and physiotherapist. One responder did not indicate his/her profession and is marked as unspecified. Feedback received according to professional background is shown in figure 1.

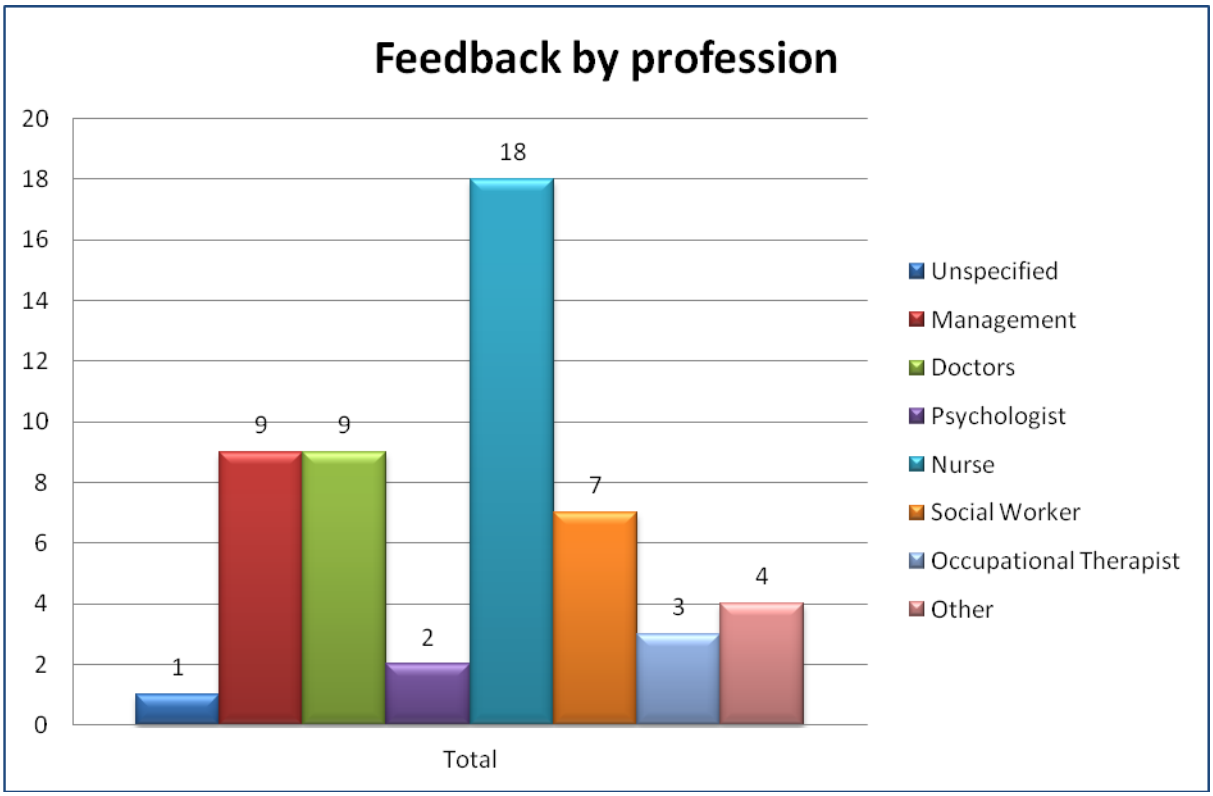


Figure 1: Feedback received by profession

Structured Feedback

Total scores (in percentage points) allocated to each category are depicted in Table 1. Each variable could be evaluated as poor, fair, good or very good. To facilitate evaluation, a score was arbitrarily given for each rating with poor=0; fair=1; good=2 and very good=3 points. The category which scored highest was that related to the facilities and accessibility of venue (87%) whilst time allocated to questions from the floor scored lowest (64%). The inadequate question time score can be justified due to the fact that some presentations over ran their allotted time and thus time was recuperated by decreasing the question time.

Seminar Variable	Total Score (%)	Ratings (crude numbers)				
		Very Good	Good	Fair	Poor	Unrated
Facilities & Accessibility	87	32	19	1	0	1
Concept	83	27	25	1	0	0
Set up	83	27	25	1	0	0
Quality of Presentations	75	18	30	5	0	0
Length of Presentations	72	16	30	5	1	1
Adequate Question Time	64	14	23	12	3	1
Workshop Discussions	81	30	17	5	1	0
Effective use of time	77	20	29	4	0	0
Met Expectations	74	18	29	6	0	0

Table2: Score by category

	Profession							
Appraisal	Unspecified	Management	Doctor	Psychologist	Nurse	Social Worker	Occupational Therapist	Others
1						1		
2		2	6	1	6	3		1
3	1	7	2	1	12	3	3	3
(Unrated)			1					
Grand Total	**1**	**9**	**9**	**2**	**18**	**7**	**3**	**4**

Table 3: Facilities & accessibility

Appraisal	Profession Unspecified	Management	Doctor	Psychologist	Nurse	Social Worker	Occupational Therapist	Others
Fair						1		
Good	1	4	6		9	2	1	2
Very Good		5	3	2	9	4	2	2
Grand Total	**1**	**9**	**9**	**2**	**18**	**7**	**3**	**4**

Table4: Concept

Appraisal	Profession Unspecified	Management	Doctor	Psychologist	Nurse	Social Worker	Occupational Therapist	Others
Fair						1		
Good	1	5	6		6	3	1	3
Very Good		4	3	2	12	3	2	1
Grand Total	**1**	**9**	**9**	**2**	**18**	**7**	**3**	**4**

Table 5: Set up

Appraisal	Profession Unspecified	Management	Doctor	Psychologist	Nurse	Social Worker	Occupational Therapist	Others
Fair			3		2			
Good	1	5	6	1	6	6	3	2
Very Good		4		1	10	1		2
Grand Total	**1**	**9**	**9**	**2**	**18**	**7**	**3**	**4**

Table 6: Quality of presentations

Appraisal	Profession Unspecified	Management	Doctor	Psychologist	Nurse	Social Worker	Occupational Therapist	Others
Poor					1			
Fair		1		1	2		1	
Good		4	8	1	8	5		4
Very Good	1	4			7	2	2	
(Unrated)			1					
Grand Total	**1**	**9**	**9**	**2**	**18**	**7**	**3**	**4**

Table 7: Length of presentations

Appraisal	Profession Unspecified	Management	Doctor	Psychologist	Nurse	Social Worker	Occupational Therapist	Others
Poor		1	1		1			
Fair		2	3	2	4	1		
Good		4	4		7	5		3
Very Good	1	2	1		5	1	3	1
(Unrated)					1			
Grand Total	**1**	**9**	**9**	**2**	**18**	**7**	**3**	**4**

Table 8: Adequate question time

Appraisal	Profession Unspecified	Management	Doctor	Psychologist	Nurse	Social Worker	Occupational Therapist	Others
Poor					1			
Fair			2	1	2			
Good		1	3	1	6	2	2	2
Very Good	1	8	4		9	5	1	2
Grand Total	**1**	**9**	**9**	**2**	**18**	**7**	**3**	**4**

Table 9: Workshop discussions

Appraisal	Profession Unspecified	Management	Doctor	Psychologist	Nurse	Social Worker	Occupational Therapist	Others
Fair			2		1	1		
Good	1	2	7	2	10	2	2	3
Very Good		7			7	4	1	1
Grand Total	**1**	**9**	**9**	**2**	**18**	**7**	**3**	**4**

Table 10: Effective use of time

Appraisal	Profession Unspecified	Management	Doctor	Psychologist	Nurse	Social Worker	Occupational Therapist	Others
Fair			2		2	1		1
Good	1	4	6	2	9	3	2	2
Very Good		5	1		7	3	1	1
Grand Total	**1**	**9**	**9**	**2**	**18**	**7**	**3**	**4**

Table 11: Met expectations

	Management	Doctor	Psychologist	Nurse	Social Worker	Occupational Therapist	Others
Facilities & accessibility			√	√			
Concept			√				√
Set up			√	√			
Quality of presentations							
Length of presentations							
Adequate question time						√	
Workshop discussions	√	√			√		√
Effective use of time							
Met expectations							

Table 12: First preference for rating of seminar variable by profession

The workshop discussions' category was the preferred choice of the highest number of professional categories including management, doctors, social workers and others. This section was rated as being very good by eight out of nine persons in management, four out of nine doctors, nine out of eighteen nurses and five out of the seven social workers. This is a positive finding given that discussions formed the core of the seminar.

Unstructured Feedback

The participants were asked how the information obtained from the seminar would help them in their everyday work. This question was answered by 79% or 42 of the respondents. There were only two respondents who stated that the information obtained would not impact on their everyday work. However, all the other comments were positive and perceived the seminar as a tool for implementing change, increased their motivation and helped them be more sensitive to the needs and rights of the patients. They also stressed that implementation of the concepts discussed is imperative and that practices from the business sector should be adopted and adapted in the mental health sector.

Nearly three fifths (59%) of the respondents wrote down a comment. These mainly focused on the various needs that are required in the mental health sector, namely to implement change, to receive more training on the Mental Health Act, to empower line management, to acknowledge the efforts of the workforce and safeguard it from burn out, to encourage more team work and to increase employee satisfaction. One person suggested that the office of the Commissioner was to be more in touch with patients' realities and needs. The participation of patient representatives was suggested, which is a very valid comment.

Conclusion

The feedback received was overall very constructive and participants positively acknowledged the participation of professionals from the business sector, which in many times is perceived to be more efficient than the public sector, in a bid to adopt and adapt their practices into the public sector. The workshops were highly appraised by 4 categories of healthcare professionals probably because they provided an opportunity for healthcare professionals to discuss issues they encounter on a day to day basis with management. Also, changes in practice instigated by the enactment of the Mental Health Act and how these would impact on their daily duties were also explored.

Negative remarks will also be taken on board. The seminar variable that was heavily criticized is the inadequate question time, and as already mentioned, this was attributed to the fact that certain speakers did not keep to the allotted time. Better time management would be a target for any forthcoming events.

The feedback provided shows that the conference has rekindled and strengthened the resolve of the many dedicated professionals to continue improving the service through a multi-disciplinary patient-centred approach whilst being more aware of the needs and rights of those entrusted to their care. It has also triggered the formation of synergies and better understanding between management and staff. This cannot but augur well to the successful implementation of the Mental Health Act and the ensuing leap in quality of mental health care.

Business solutions: any gains for mental health?

Seminar Organised by the Office of the Commissioner for Mental Health and Older Persons

Tuesday 10th June 2014

Le Meridien Hotel, St Julians

Feedback/Evaluation Form

Dear participant,

Please take a couple of minutes to complete this evaluation form as feedback will help us improve future events.

Profession: Management ☐ Doctor ☐ Psychologist ☐ Nurse ☐ Social Worker ☐

Other ☐ *please specify* _____

	POOR	FAIR	GOOD	VERY GOOD
Seminar Facilities & Accessibility				
Seminar concept				
Seminar set up				
Quality of presentations				
Length of presentations				
Adequate question time				
Workshop discussions				
The programme was an effective use of my time				
The Seminar met my expectations				

1. How will the information gained at this seminar help you in your work?

_____
_____
_____
_____

2. Please put down any additional comments

_____
_____
_____

Thank you