Country Profile Malta

Community-based Mental Healthcare Networks: Key Facts and National Priorities

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1 Introduction

The EU-Co-funded "Joint Action on Implementation of Best Practices in the area of Mental Health", short **JA ImpleMENTAL** has a duration of 3 years, lasting from October 2021 to September 2024. Detailed information can be found at the project's website JA ImpleMENTAL (ja-implemental.eu). It aims to promote and improve mental health structures, services, capacity and outcomes in participating countries in 2 specific areas:

- mental health reform (promoting community health services) and
- suicide prevention.

Two national best practices - mental health reform in Belgium and the Austrian suicide prevention programme SUPRA - serve as best practice examples. Selected components of these should be prioritised and implemented over the course of the JA in 14 i.e. 17 participating EU-countries. JA ImpleMENTAL comprises six Work Packages (WPs), four horizontal WPS and one for each best practice. WP5 on community-based mental healthcare aims to implement elements from Belgian Mental Health Reform, which is based on the principle of deinstitutionalization, i.e., the transition from care primarily provided in institutions to community-based care in order to improve mental health outcomes and quality of life and avoid unnecessary hospitalizations. In addition, the reform is based on the principles of rehabilitation and inclusion, decategorization, i.e., multisectoral cooperation, strengthening care in hospitals to make stays shorter, but with more intensive treatment, and the principle of consolidation, providing funds for pilot projects.

The present country profile is one of the major deliverables of the JA, presenting key facts of the national and local mental health system. It summarizes results of the recent situation analysis and needs assessment (SANA), lists lessons learned, recommendations, challenges and opportunities as well as outlining next steps necessary to scale-up, promote national/regional community-based mental health care services. The country profile forms a basis for strategy formulation, decision-making and commitment.

This country profile is based on a situation analysis conducted in two parts and subsequent needs assessment. For the situation analysis, two questionnaires have been developed by WP5, one for the analysis of the situation regarding the overall health system and community-based mental health care at national level, and another one for the analysis at implementational level. Following the data collection, a SWOT analysis was conducted by the countries to assess the needs in terms of community-based mental health care.

SANA Part II

The pilot area chosen is the Southern Harbour and Southern Eastern NUTS regions of Malta. Data for this area was not readily available. Moreover, the NUTS region of Malta and the catchment areas of the Community Mental Health Clinics (CMHC) chosen do not coincide, presenting a challenge since population data/ characteristics cited is by NUTS regions. However, given the homogeneity of the population in the region, it is safe to assume that the data/ characteristics presented are very much in keeping with the population of the pilot area.

2 Situation Analysis (SA)

2.1 Country, Health, and Social System at national level

Malta is an archipielago in the Mediterranean Sea, consisting of three inhabited islands Malta, Gozo and Comino. The resident population stood at 519,562 at the last census in November 2021, more than doubling over a century, and increasing by more than 100,000 residents over the past 10 years. Malta remains the most densely populated country in the European Union (EU) with 1,649 residents per square kilometre (1). The population structure is depicted in Table 1.

Table 1: Population structure for the year 2021, expressed as number of persons, by age and sex (2)

	Sex		
Age group	**Male**	**Female**	**Total**
<18	42,484	39,646	82,130
18 - 64	179,726	156,826	336,552
65+	44,729	52,689	97,418
Total	266,939	249,161	516,100

Healthy life years at birth, in 2020, in Malta for women was 70.7 years, whilst for men was 70.2 years (2). A total of 20.3% (2021) of the population was at risk of poverty and social exclusion (3). Income inequality, expressed as the Gini coefficient, is 30.3 (4), and total healthcare expenditure relative to GDP is 8.95 % (5). The proportion of Years of Life Lost due to Disability (YLD) due to mental and substance abuse disorders, to number of YLD due to all causes, is 14.7% (6).

Malta's National Health Service (NHS) is predominantly financed through general taxation, and provides almost universal coverage to all residents. The Ministry for Health, is responsible for governance, regulation and financing of the health system, and is the main provider of public health services including mental health services (7).

The vision of Mental Health Services (MHS) is included in the Mental Health Strategy 2020 – 2030, which is being implemented over a 10-year period, through a series of actions grouped into four clusters, namely: 1) Promoting mental health and wellbeing by addressing the wider determinants of health, 2) Transforming the framework within which mental health services are delivered, 3) Supporting all persons with mental disorders and their families, 4) Building capacity and fostering innovation to improve the performance of our mental health services.

2.2 Mental Health System at national level

Mental health strategies, policies and legislation

Malta has a stand-alone strategy for mental health, which was published in the year 2019 (8). The strategy favours deinstitutionalisation, by encouraging persons with a mental disorder to live in the community, making community services the mainstay of care. The strategy adopts a human rights approach, supports a recovery-oriented, person-centred care, involving a multi-disciplinary team, with the patient and the responsible carer being part of the team and participating in the decision-making process.

Malta does not have a policy, strategy, or plan for child and/ or adolescent mental health. However, an internal protocol has been established to enhance the smooth transition between child/ adolescent mental health services to adult mental health services.

Mental Health Practices are guided by the 2012 Mental Health Act (MHA) (9), which promotes (i) the transition of mental health services from inpatient care to the community setting; (ii) supported decision making and advance directives; and (iii) the prevention of coercive practices and (iii) establishes the Commissioner for the rights of persons with a mental disorder. The MHA also promotes care in the least restrictive way.

Collaboration between entities

There is ongoing collaboration between Ministryfor Health (MFH) and other ministries, including the Ministry for Social Policy and Children's Rights, the Ministry for Education, Sport, Youth, Research and Innovation, the Ministry for Justice. Further collaboration is ongoing with the office of the Commissioner for persons with a mental disorder, Non-Governmental Organizations (NGOs) and family/ caregiver advocacy groups and other entities (8).

Services offered

Mental Health care services including inpatient and community care, , are offered free at the point of use to people entitled to statutory provision. This includes free medication on the National Government Formulary (6).

The total government expenditure on mental health as a percentage of total public health expenditure is 6.83% (10). The share of people reporting unmet mental health care need due to financial reasons, was 2.1% in 2014 and 1.6% in 2019 (11).

The majority of persons with severe mental health conditions, and also some with non-severe mental health conditions, receive income, housing, employment, education, social care as well as legal support from the government. There is additional assistance from NGOs, in the case of housing and social support (6).

The mental health workforce

The mental health workforce for adults and children/ adolescents, consists of several healthcare professional categories, as specified in Table 2.

Inpatient and outpatient mental health structures

There are a number of hospital-based and community-based mental health outpatient services.

Table 2: Mental health workforce, 2022 (14)

	In MH service (all)		In child & adolescent MH services (totals of government and non-government services)	
	Total number	Rate per 100,000 adult population	Total number	Rate per 100,000 minor population
Psychiatrists	38	7.4	---	---
Child psychiatrists			3	3.7
Mental health nurses	416	80.6	12	0
Psychologists	47	9.1	2	0
Social workers	13	2.5	1	0
Speech therapists	10	1.9	0	0
Occupational therapists	26	5.0	2	0
Others*	13	2.5	0	0
Total	563	109.1	0	0

*Others include: Five Allied HCWs in Management, four Physiotherapists, three Podiatry, one Dietician and one teacher.

Hospital-based services

Hospital-based services in Malta are provided at the main public Mental Health hospital (Mount Carmel Hospital). The psychiatric unit that formed part of the main general (acute) hospital (Mater Dei Hospital) in Malta, was closed down in 2020. In Gozo, the psychiatric wards (short- and long-stay wards) are situated on the same footprint as the Gozo General Hospital (GGH). Mental health inpatient facilities, specifically for children and adolescents, are located at Young People's Unit (YPU), at Mount Carmel Hospital. GGH does not have specific inpatient facilities for children and adolescents.

Facilities, number of beds and hospital admissions for adult mental health (AMH) and child and/or adolescent mental health (CAMH), are detailed in Table 3.

In 2021, the proportion of involuntary admissions (575), to the total number of admissions (1819) in Malta was of 0.3, whilst the proportion of involuntary admissions (25), to the number of total admissions (118) to psychiatric units of general hospitals (Gozo), was of 0.2.

In 2022, around 75% of the persons discharged from a mental health hospital were followed up within one month, in the community setting (12).

The number of inpatients for 2021 in Malta and Gozo is depicted in Table 4.

Table 3: Facilities, number of beds and hospital admissions related to mental health (13, 15)

Indicator at national level		Number	Rate per 100,000 adult/minor population
Mental health hospitals (2021) (12)	Facilities	1	0.46
	Beds	268	61.76
	Admissions	1819	419.15
Psychiatric wards/units of general hospitals (2021) (12)	Wards/units	2	0.46
	Beds	52	11.98
	Admissions	118	27.12
Mental health community residential facilities (2021) (11, 12)	Facilities	42	9.7
	Beds	241	55.5
	Admissions	133	30.6
Mental health inpatient facilities specifically for children and adolescents (2021) (12)	Facilities	1	1.2
	Beds	10	12.2
	Admissions	85	103.5
Mental health community residential facilities specifically for children and adolescents (2021) (14)	Facilities	1	1.2
	Beds	9	11.0
	Admissions	0*	0

* There was no turnover of patients during the year 2021 i.e. no admissions or discharges

Table 4: Proportion of long-stay patients by length of stay in mental health hospitals (14)

Number of inpatients	Malta	Gozo	Total
Length of stay of more than one year (up until 31st December 2021)	47	32	79
Any length of stay (up until 31st December 2021)	185	43	228

Community-based services

The hospital-based outpatient services in Malta, were transferred to the community mental health clinics during the COVID-19 Pandemic. At present there are seven community mental health clinics. In Malta, there is one community-based outpatient facility service specifically for children and adolescents. In Gozo, the child and adolescent outpatient services, are delivered from the outpatients department of the mental health. Community Residential facilities in Malta (and Gozo) do not accept involuntary admissions.

Role of primary care doctors in the Mental health system

Primary care doctors do not have a specific role in the Mental Health system, but there are two Community Mental Health clinics sited within the Primary Health Care (PHC) facilities. Currently, MHS and PHC collaborate on an informal basis however, there are plans for MHS and Primary care services

to be co-located at the same premises/ hub. This will strenghten the collaboration between both parties.

Mental Health Information System

Malta does not have a stand-alone Mental Health Information System (MHIS) at national level, however, MHS is working towards establishing such a system. Mental health data are not compiled in a specific mental health report. There is no minimum mental health data/ indicators' set, that is defined at governmental level.

2.3 Population profile in pilot area

The pilot areas for the implementation of elements of the Belgian Best Practice, are the catchment area of the Paola and Cospicua Mental Health Clinics, both situated close to the respective Rehabilitation Centre and the Primary Health Clinic. The pilot area chosen is situated in the Southern Harbour and the Southern Eastern region of Malta. Data for this area is not readily available (Table 5).

Table 5: Population structure in 2021 of pilot area (Paola and Cospicua Mental Health Clinics) expressed as number of persons, by age and sex (17).

	Sex		
Age group	**Male**	**Female**	**Total**
<18	12,852	11,699	24,551
18 - 64	50,780	43,937	94,717
65+	13,676	15,762	29,438
Total	**77,308**	**71,398**	**148,706**

The life expectancy for the general population in 2021 was 84.5 years on average for women, and 80.3 years for men. The national unemployment average seasonally adjusted rate for the year 2022 was 2.96%. Sample population in the catchment area is of around 148,706 people (14). Current active service users are around 2,425 (11). Any person, over 18 years of age, living in the catchment area may avail of the services.

Of note is that the unemployment rate and life expectancy figures for the pilot area are not available, however, these are similar to that of the general population.

2.4 Community-based mental health care at pilot level

Key developments and policies

Mental Health Inpatient and Community Services are governed by the Mental Health Act and the Mental Health Strategy for Malta 2020-2030. However, the Mental Health Strategy is not integrated into other general policies.

Community mental health services are provided by multi-disciplinary teams with community services being preferred to inpatient services (8). Funding comes from the global budget for Mental Health Services, that is, there are no allocated funds specifically for these Community Mental Health Clinics.

Common procedures for a smooth transition between child/ adolescent to adult mental health services exist. To this end, there is an internal protocol, mainly focusing on Hard to Reach Young People.

Stakeholder environment

There is ongoing collaboration in the area of MH between governmental/ Public Health authorities/ services and other non-health authorities/ services, which however is not formalised. Referrals and liaison between entities occurs on a case by case basis. There are NGOs and private entities in the pilot catchment areas such as Richmond Foundation, and St Thomas Community Living, who collaborate with MHS in providing residential and community support and rehabilitation services. There is a residential long term facility for persons with intellectual disability in this region. Public Social Services are located In pilot area.

Available and used Community based Mental Health services

There is a National telephone helpline and a Crisis Resolution Home Treatment Team which provides a nation-wide service. There are no psychiatric wards in a General Hospital (acute) in the pilot area. There are three mental health community residential facilities, one of which caters for persons with intellectual disability, some of who may be children or adolescents.

There are two community-based facilities/ services. Community services, assess adults of 18 years and above, who have been referred to the service. Both new and follow- up cases are seen at the clinics. The Community Clinics also provide Outreach Services.

In 2022, the total number of admissions referred from the pilot area to the main psychiatric hospital in Malta was 78 (68 admissions from Poala and 10 admissions from Cospicua). No data stating the mode of admission is available. Community residential facilities do not accept involuntary admissions. In the last year (2022), around 51%-75% of adult inpatients received a follow-up outpatient visit within one month of discharge from hospital.

Workforce in Mental health

The total number of MH workers in the pilot area is presented in Table 6, given as Full Time Equivalence (FTE).

MH promotion activities are nation-wide and activities target the whole population. There are school-based activities to promote MH. MHS liaise with educators for such ad hoc activities. The education system has its own counsellors and psychosocial teams.

Table 6: Total number of MH workers in the pilot area, 2022 (14)

	In MH services (all)		In child & adolescent MH services	
	Total number	Rate per 100,000 adult population	Total number	Rate per 100,000 minor population
Psychiatrists	4	0.3	----	----
Child psychiatrists			0	0
Mental health nurse	10	0.7	0	0
Psychologists	3	0.2	0	0
Social workers	2	0.1	0	0
Speech therapists	0	0.0	0	0
Occupational therapists	4	0.2	0	0
Others*	5	0.3	0	0
Total	28	1.8	0	0

*In the 'Others' category there are three carers and two clerks and 0.2 GP (FTEs).

Mental Health at primary care level

There is one primary health doctor operating from the Cospicua Mental Health clinic (once a week), and none at the Poala Mental Health clinic. There is no formal system for collaboration between primary care and specialised care level, however, informal collaboration takes place on an individual basis.

There are currently no guidelines for MH integration into Primary Health care. Primary care doctors can prescribe psychiatric medication to patients. General Practitioners do refer patients to psychologists within the pilot community clinic.

Health workers, physicians/medical doctors, paediatricians at primary care level receive *pre-service training* at undergraduate level on management of MH conditions. GPs may opt for a training attachment/ rotation with MHS. There is no formalised and/ or compulsory in-service training in mental health for health workers, physicians/ medical doctors, and paediatricians at primary care level.

3 Needs Assessment (NA)

The SWOT analysis was done via several discussions in collaboration with hospital management, different Health Care Professionals working within the Mental Health Sector and professionals working outside the mental health sector. This process followed the 'JA Implementation Strategy Guidelines to perform the SWOT analysis'. The results are shown in Table 7.

Table 7: SWOT analysis

Strengths	Weaknesses
1. Good leadership within MHS 2. Strong networking with community stakeholders 3. Ongoing training to all healthcare professionals 4. MHS has its own ring-fenced budget that is increased every year 5. Innovative ideas and new services on an annual basis 6. The working in MDTs lends itself to wider pooling of ideas and increased creativity 7. Participation in international initiatives giving a wider outlook on innovation taking places in the participating countries 8. MHS benefits from marketing initiatives undertaken by the Ministry for Health where MHS lends its expertise on mental health 9. MHS work closely with the Health Promotion Directorate	1. Career pathway is steep, and there is minimal use of performance appraisal, causing demotivation, loss of HR to private sector where income is more lucrative 2. Shortage of human resources resulting in burnout and recruitment of foreign nurses and carers. The latter creates cultural and language barriers 3. Professional unions are there to check that the rights of the worker are upheld, but at times they become too militant and may jeopardize patients' well-being 4. More training on recovery-oriented practices needs to be embraced further across MHS 5. Change in culture and practice within MHS presents a challenge 6. MHS does not have a PR Officer. This results in our limitation to counteract social media misinformation, disinformation, and sensationalism. This also limits efforts to counteract stigma with regards to mental health. 7. MHS needs to measure performance through KPIs.
Opportunities	**Threats**
1. There is political will to develop MH services 2. Malta, being a small island encourages communication both within MHS and with other stakeholders 3. Malta's performance compares very well compared to other EU member states. GDP growth is expected to be 3.1 down from 3.6 in 2022 and is expected to increase to 3.7% in 2024. 4. The influx of foreign workers and asylum seekers demand diversity of services. 5. Technology is a government priority, and this will hopefully translate in a mental health dedicated IT system. 6. Mental Health Act and Mental Health Strategy guide MH practice and service development. Health & Safety law is also enacted. 7. Government issues initiative towards environmentally friendly projects (including waste separation). Environmentally friendly building policies are followed in the psychiatric hospital refurbishment, including water reservoirs and embellishment of the hospital's outdoor areas.	1. Competing interests including post-pandemic and Ukrainian war. Acute physical care gets more attention when compared to MH care 2. Although Malta is doing well economically, there is a slight increase in the at-risk poverty or social exclusion rate (AROPE) which stands at 20.3%. This increased by 0.4 percentage points in 2021 when compared to 2020, according to the European Statistics on income and Living Conditions Survey. 3. Social change brought about challenges in the leasing market & cost of living. This will have a negative impact on mental well-being. 4. Lack of training and capacity to deal with increase in population and the related population diversity 5. No off-the shelf IT system that addresses the needs of MH services 6. Reinforcement of current legislation regarding employment and social welfare would ensure equal rights and opportunities as supported by the UN-CRPD. Legislative framework for the recruitment of peer experts does not exist. 7. Green initiatives need to be encouraged and reinforced, and green spaces created and protected.

4 Reflection on SANA results

Box 1. Prioritized measures for pilot implementation

- Measure 1 Recovery throughout the mental health services using the biopsychosocial model
- Measure 2 Care during transition from inpatient to community services
- Measure 3 Improved collaboration with primary care specialists
- Measure 4 Exploring ways on how to recruit peer specialists leading to co-production

POTENTIAL SUCCESS FACTORS

- ✓ Success factor 1: Building capacity of Mental Health Workforce
- ✓ Success factor 2: Service user empowerment

Defining and prioritizing the measures

Measures 2 and 4 were chosen following two focus groups with service users. These were then presented and discussed with management and the WP5 working group. Discussions are underway between MHS and Primary Care Physicians to foster further collaboration to enhance comprehensive care.

There are ongoing talks and training initiatives with Belgian Best Practice professionals, peer experts and with local NGOs with regards to the recruitment of experts by experience. In addition, the WP5 team is undertaking research to obtain first-hand information to ensure that the system adopted would be relevant and targets our needs.

Two training sessions on Peer Experts and Co-Production and the Collaborative Care Model to improve collaboration between primary care doctors and psychiatrists have been provided by the Istituto Mario Negri. There have been other opportunities of training within and outside the JA on peer experts and co-production.

Reflections on SANA results

SANA has focused on the strengths and weaknesses of our system. Mental Health Services are committed to improve the services being offered. One of the priorities, is to provide seamless and supported transition for service users between inpatient and community services, through enhanced collaboration and communication between services. To this effect, MHS are working on a protocol to ensure that support is given to service users during this transition. Another priority is the provision of timely services, including emergency and/ or outreach services. Barriers to the latter are the lack of human resources and resistance to change by staff. SANA results showed that data at population level and at service level is not readily available and should be scaled-up.

Strengthening of the collaboration with other ministries, NGOs and other health services is warranted. The role of experts by experience has been encouraged by the Joint Action, so much so, that experts have been part of our WP5 team from the outset. MHS are seeking every opportunity to be informed about the engagement, recruitment, and training of experts by experience. Moreover, a recovery

academy has been set up to encourage mental health literacy and to engage peer experts with the aim of co-production.

5 Priorities & Next steps

Mental Health Services have taken note of the suggestions put forward by the stakeholders during a seminar that was carried out on the 2nd of May 2023, to present the Country Profile. Mental Health Services through their participation in ImpleMENTAL are committed to:

- Scaling up of mental health services, including the transition between services
- Building capacity of the mental health workforce and providing the necessary support to ensure quality in service delivery
- Strengthening the collaboration with stakeholders including primary care and NGOs
- Applying the recovery model throughout all services
- Exploring ways how to engage and recruit experts by experience with the aim of Co-production

6 Priorities

Box 1.

POTENTIAL SUCCESS FACTORS

- motivation of MH staff in learning psychosocial treatments based on evidences for caring adolescent patient with conduct disorder and young adult with BPD
- existing network of MH services for children-adolescents and adults and (at least in some MH services) of staff specialized in the care of adolescents/young adults with severe mental disorders
- structured model of implementation of the best practice
- existing MHIS in the adult sector to monitor the implementation process
  All staff involved in the training and implementation is regularly employed by the services and not timely recruited for this specific project. In this way the continuity and sustainability of care delivery after the conclusion of the JA is better assured.

PRIORITIZED MEASURES FOR PILOT IMPLEMENTATION

1st STRATEGIC AREA: Ensure (strong) governance structures/mechanisms

- **Sub-strategic area 1.1: Governance conditions**
  a) Setting up of a Recovery and Wellbeing Academy which is regulated through protocols that ensure that the Academy develops in a person-centred educational hub which nurtures hope, empowerment, mental wellbeing, and recovery. The Recovery and Wellbeing Academy combines personal lived experience with professional knowledge to offer unique learning opportunities for mental wellbeing and recovery, whilst improving mental health literacy (January 2023-ongoing).
  b) Protocols are developed to guide practice that shall ensure a seamless transition from inpatient to community care (July 2023 – June 2024).

- **Sub-strategic Area 1.2 Building, (consolidating or extending) and sustaining networks based on intersectoral, multidisciplinary and recovery-oriented approach (at pilot Site)**
  a) Discussions with primary care specialists especially General Practitioners and specialists in psychiatry *(Q4 2022 – ongoing).*
  b) Protocols guiding the recovery-oriented approach. To improve knowledge about person-centred care focusing on patient rights; the provision of WHO e-training on Quality Rights to be offered to all healthcare professionals working within MHS (Q1 2024).
  c) Exploring ways on how to meaningfully recruit experts by experience, provision of training to service-users and the public through the Recovery and Wellbeing Academy *(Q1 2022-ongoing).*
  d) Scaling up of Mental Health Services including the transition from inpatient to community services, MHS plan that there is greater collaboration and communication between healthcare professionals within the inpatient facility and the community services *(Q2 2023-ongoing).*

2nd STRATEGIC AREA: Development or transformation of MH services and interventions (incl. multi-disciplinarity approach)

- **Sub-strategic area 2.1: Developing new (non-existing) OR transforming/adapting existing MH services (incl. reinforcement of multi-disciplinarity and improvement of evidence-base, quality, efficiency and continuity of services) in the areas of (five functions of the Belgian BP):**

  a) Develop protocols to guide practice for a seamless transition from inpatient to community care, through improved communication between healthcare professionals in both points of care and to improve patient support during this vulnerable period *(Q3 2023-Ongoing).*

3rd STRATEGIC AREA: Extensive global training programme of stakeholders (in support of the reform & cultural change in service provision)

a) Training of Healthcare professionals working within Mental Health Services through the provision of WHO e-training on Quality Rights to improve knowledge on patient rights to uphold such rights during service delivery *(Q1 2024).*
b) Improved Mental Health literacy through Recovery and Wellbeing Academy (RAWA) which is offered to service-users and the general public. The curriculum, content of modules and delivery of such lectures are co-produced with peer experts.

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