N A O
National Audit Office
MALTA

# Performance Audit: A Strategic Overview of Mount Carmel Hospital

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# Performance Audit

## A Strategic Overview of Mount Carmel Hospital

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# List of Abbreviations

| | |
|---|---|
| CCTV | Closed-Circuit Television |
| CEO | Chief Executive Officer |
| CNM | Chief Nursing Manager |
| COO | Chief Operations Officer |
| CYPS | Children and Young People's Services |
| FC | Financial Controller |
| FSW | Female Seclusion Ward |
| HR | Human Resources |
| ISSAI | International Standards of Supreme Audit Institutions |
| MCH | Mount Carmel Hospital |
| MDH | Mater Dei Hospital |
| MFH | Ministry for Health |
| NAO | National Audit Office |
| NGO | Non-Governmental Organisation |
| ORS | Online Request System |
| SVPR | St. Vincent de Paul Residence |
| WHO | World Health Organisation |
| YPU | Young People's Unit |

# Executive Summary

**Mount Carmel Hospital's current unacceptable condition is the result of the long-standing legacy of central Government's lack of commitment towards mental health.**

## Why This Study?

With the World Health Organisation asserting that mental health disorders are set to become the leading cause of the global burden of disease, NAO conducted this review to determine whether Mount Carmel Hospital, being the central national hub tasked with dealing with such conditions, is operating efficiently while effectively addressing society's mental health needs.

## What NAO Recommends

NAO opines that an all-encompassing national strategy on mental health needs to be implemented at the earliest to ensure the effective overhaul of MCH and to address the prevalent negative stigma on mental health. This Office also strongly recommends that any future mental health strategy should have community services as its flagship. NAO however contends that this is not possible without the full commitment of central government, particularly through the investment of the required capital and recurrent resources at the earliest.

## NAO's Key Observations

While NAO acknowledges Government's stated pledge to invest some €30million to address MCH's current unacceptable structural condition, it however asserts that this hospital's significant operational challenges are much more widespread. Consequently, NAO contends that if this capital investment is not accompanied by an upward revision in the hospital's recurrent financial allocation, together with an overhall of its operations, significant inefficiencies and ineffectiveness would still prevail.

Apart from a pronounced shortage in HR, particularly in the nursing grades, this Office also observed that relations between the hospital's management and its staff are generally strained. Specifically, NAO noted how MCH personnel feel isolated and directionless while, on the other hand, MCH management feels that the former's militant approach towards industrial relations impinges on the efficiency and effectiveness of the hospital's operations.

NAO also concludes that MCH's security arrangement is largely inadequate. This Office observed how the deployed security complement is not carrying out all security functions, particularly those involving the physical element (such as searches or restraint), as well as those relating to the monitoring of the hospital's master keys. Some of these functions are instead carried out by nursing staff. The audit team also noted that security at the hospital's main gate is loosely implemented and that the CCTV system in place leaves much to be desired.

This study also showed that MCH is partially serving as a place of last resort to a significant number of individuals who, though possibly in need of assistance and other targeted services, do not require hospitalisation in a mental health institution. This situation, NAO asserts, is putting further strain on the already stretched resources, and consequently, on the level of service offered to the mental health patients who do require hospitalisation.

NAO also found that while the desired way forward is to push mental health services towards community care, MCH's community clinics and day centres are generally understaffed and that the required attention from the hospital's management towards this function is lacking.

Finally, this Office observed how a comprehensive national strategy for mental health is still not in place. This situation, NAO opines, creates a vacuum in the vision and overall direction for this critical area within the local health sector.

# Chapter 1

## Introduction

**This introductory chapter contextualises the audited area and presents the study's overall scope, objectives and adopted methodology. These are followed by a synopsis of the report's chapters.**

### 1.1. Why this study?

Untreated mental disorders exact a high toll, accounting for 13% of the total global burden of disease

Current predictions indicate that by 2030 depression will be the leading cause of disease burden globally

Source: World Health Organisation (2011)

1.1.1. Mount Carmel Hospital (MCH) is Malta's central hub specifically tasked with promoting good mental health and providing treatment to persons suffering from mental health illnesses. As stated by the World Health Organisation (WHO), mental health disorders are a significant contributor to the total global burden of disease, with their effects forecasted to become even more pronounced in the near future. The local situation is no exception and consequently, this prevalent concern, and the hospital's significant recurrent yearly financial allocation, prompted the National Audit Office (NAO) to conduct a performance review intended to assess the efficiency and effectiveness of this institution's operations.

### 1.2. Background Information

1.2.1. MCH is intended to tackle the full spectrum of mental health illnesses, and is therefore bound to offer a comprehensive range of hospital and community mental health services. This hospital and its services fall under the responsibility of the Ministry for Health (MFH), absorbing an average of €33million from the Government's annual budgeted expenditure.

1.2.2. As at time of writing of this report, MCH accommodated approximately 530 in-patients within its wards and provided services to approximately 11,750 outpatients within the community. The hospital has a total staff complement of 679, of which approximately 540 (being medical practitioners, nurses, social workers etc) have direct contact with the hospital's patients. The hospital is segmented into 25 wards, each intended at assisting specific groups of patients, based on factors such as age, gender, type of condition, severity of symptoms and security requirements.

1.2.3. Apart from services offered directly within the hospital premises, MCH also provides a number of mental health services within the community, mainly through its ten mental health clinics and five day centres.

1.2.4. Amongst others, MCH's operations are governed by the Mental Health Act (Chapter 525 of the Laws of Malta) and are subject to scrutiny by the Mental Health Commissioner.

## 1.3. Audit Scope and Objectives

1.3.1. This audit focuses solely on MCH as the central hub for mental health treatment and the services it provides within the community. This study therefore omits any other mental health services provided by Government or local Non-Governmental Organisations (NGO). No specific time parameters were set for this study, rather the findings presented in this report reflect the state of affairs of the hospital and its operations as at time of writing.

1.3.2. In view of the wide spectrum of issues which NAO felt merited its attention, the audit team was compelled to approach this exercise from a strategic perspective. This, NAO feels, was the best approach to maximise the effectiveness of this audit exercise, rather than embarking on a microanalysis of a single issue. This strategic perspective lead the audit team to scope the study around the hospital's main operational areas (Figure 1 refers). Consequently, and also in view of this adopted strategic approach, each of the identified issues were not individually pursued through in-depth analysis, but rather used to substantiate more elevated observations on the hospital's overall performance. In essence therefore, this exercise brings together what the NAO saw as being the key contributory factors to MCH's current state of affairs.

1.3.3. It is important to note that, during its review, the audit team observed a number of issues other than those reported in this study. While these were not tackled in this report as they did not fall within this audit's set scope, this Office, however, does not exclude further analysis on these identified issues in separate studies.

1.3.4. The audit team deployed on this study was tasked to assess MCH's operations from strictly an administrative performance perspective, thereby steering clear from any analysis on the medical front.

1.3.5. Through this strategic analysis therefore, NAO sought to determine whether MCH and its services within the community are effectively and efficiently tackling mental health conditions in Malta.

Figure 1 - Audit Scope


## 1.4. Methodology

1.4.1. In preparing this audit exercise, the audit team made use of various research and analytical tools in order to obtain clear and reliable information on the audited entity and its operations.

1.4.2. During the initial stages of this study, the audit team conducted extensive preliminary research by delving into local and foreign reports and publications, media articles, as well as relevant legislation and directives. During this initial stage, the team also held a meeting with the Commissioner for Mental Health to better contextualise the audit area.

1.4.3. After acquiring a general overview of the surrounding issues, the audit team carried out a detailed issue-analysis exercise, so as to determine the main audit question. Following this, a number of sub-questions emerged, providing the audit team with a clear pathway towards the successful conclusion of this study.

1.4.4. The adopted strategic approach led NAO to opt for qualitative analyses to address this audit's questions. This study is therefore mainly based on a series of semi-structured meetings held with the hospital's various levels of management, as well as site visits conducted with MCH's front line personnel. While meetings with management generally treated a wide spectrum of issues, site visits carried out in all of MCH's wards as well as its community clinics and centres were more focused on the operations of the respective visited area. It is important to note that site visits, particularly those conducted in the MCH wards, were held with little prior notice so that the audit team would gather as much of a realistic picture of the situation as possible. Meetings and visits held by the audit team amounted to around 60 interventions and were intended at gathering and triangulating all necessary information required for the execution of this study.

1.4.5. All meetings held with MCH's management were audio recorded for ease of reference, while observations made during the conducted site visits were verified visually by the members of the audit team and documented in working paper format for referencing purposes.

1.4.6. The findings of this study, together with this Office's observations and recommendations were presented to the audited entity for its feedback and discussed during an exit conference, prior to the publication of this report.

1.4.7. The NAO conducted this performance audit in accordance with the Standard for Performance Auditing, ISSAI 3000.

## 1.5. Report Structure

1.5.1. **Chapter 1** - This introductory chapter contextualises the audited area and presents the study's overall scope, objectives and adopted methodology. These are followed by a synopsis of the report's chapters.

1.5.2. **Chapter 2** - This Chapter presents issues emanating from the state of MCH's buildings, namely through their design, structural safety and ambience, and how these effect the hospital's operations and consequently, mental health in-patients.

1.5.3. **Chapter 3** - This Chapter highlights NAO's observations on the security arrangements within MCH, namely on the security guard complement, its closed-circuit television (CCTV) system, the management of the hospital's master keys and other security risks prevalent in MCH's physical structure.

1.5.4. **Chapter 4** - This Chapter brings to the fore challenges being met by MCH insofar as financial (both recurrent and capital) and human resources are concerned. It also highlights the negative effects generated by the absence of an overall strategic plan.

1.5.5. **Chapter 5** - This Chapter presents NAO's observations on how a significant number of beds in MCH are being occupied by individuals who do not require hospitalisation within a mental health institution, particularly among those classified as geriatric persons, substance abusers and institutionalised patients.

1.5.6. **Chapter 6** - This Chapter presents the main challenges being faced by community mental health clinics and day centres and how these are affecting the quality of service being offered to mental health out-patients.

1.5.7 **Concluding remark** - This presents key overall conclusions based on the findings of the Report.

# Chapter 2

## MCH's Structural Design, Safety and Ambience: Mental Health Patients deserve much better

**This Chapter presents issues emanating from the state of MCH's buildings, namely through their design, structural safety and ambience, and how these effect the hospital's operations and, consequently, mental health in-patients.**

### 2.1. MCH's overall structure is outdated and restrictive, causing logistical and administrative challenges

2.1.1. As already indicated in Chapter 1, MCH was built as a mental health institution in the year 1860. Its layout comprises of a significant footprint with wards and buildings spreading out from the central administrative block, with most of its buildings consisting of one, at most two storeys.

2.1.2. During meetings with NAO, MCH officials stated that, in their opinion, the hospital's layout is outdated and consequently creates logistical and administrative challenges. While buildings comprising of no more than two storeys can be deemed as having an advantage (particularly, as less lifts are required and access is made easier), MCH's structures are generally outdated in their design and this makes it difficult for its management to maximise the efficiency of its operations. More specifically, NAO observed how MCH is constrained to operate from a building which was designed according to 150 year old standards, and which was originally intended to serve as an "*asylum for the insane*" (which description is still exhibited at the hospital's main gate). In one example of this, the audit team was informed that, unlike Mater Dei Hospital (MDH), wards at MCH are not built around a central nursing station. This situation, causes inefficiencies in the allocation of nurses as these will have to continually patrol their wards rather than staying in a central nursing station, tending to other work (such as documentation) while still having full visibility of all their patients. This issue becomes even more important when one considers the demanding supervision service that MCH patients require.

2.1.3. NAO feels the need to specifically point out a related shortcoming in one of the visited wards which, in this Office's opinion, puts undue pressure and risk on MCH staff. Specifically, reference is made to Ward 8B, which ward houses men with substance abuse problems (which issue will be discussed in further detail in Chapter 5). During its visit in this ward, the audit team noted that the nursing station physically separates the patients' living/ sleeping quarters from the only available bathroom. This means that every time a patient

needs to use the said facility, there is no option but for the nurses to let him through their station. During NAO's visit, the nurses deployed in this ward voiced their concern about this situation, especially in view of the generally volatile tendencies of these particular individuals who, according to MCH nursing staff, are more prone to become violent. Specifically, nurses asserted that they feel that this situation precludes them from having an effective safe place in the event of a patient generated violent incident.

2.1.4. Throughout its fieldwork, the audit team observed how a number of MCH structures present challenges to management due to their small size. The audit team noted that several MCH wards accommodate a number of patients that exceeds their intended capacity. In the most severe of these cases, NAO, amongst others, noted how beds were laid out almost touching each other, thereby restricting patients' personal space and privacy, while presenting significant physical challenges for staff to tend to the patients' needs. This consideration, NAO observes, becomes especially critical in the event of an emergency. During its visits, the audit team also observed how, in certain instances, time-out or seclusion rooms were also being used to accommodate non-volatile patients due to overcrowding. In these instances the audit team was informed by MCH officials that the door was kept open to mitigate, as much as possible, the seclusion effect of these rooms. This practice obviously meant however, that wards would be deprived from the facility of seclusion/time-out rooms, forcing staff to rely on the availability of such rooms in other wards if the need arises.

2.1.5. NAO also observed how the common areas of some of the visited wards can by no means be considered as acceptable in terms of size. For instance, the audit team observed how, in one particular ward, 28 patients together with MCH staff are constrained to spend most of their day in an area not exceeding the size of two average sized household living rooms.

2.1.6. In numerous visited wards, the audit team's attention was also drawn to the inadequacy of sanitary facilities. Specifically, nurses in charge of these wards complained with NAO how the number of available lavatories are not sufficient to cater for the needs of all patients accommodated within. The audit team also saw how a small number of wards did not have a functioning shower, forcing nurses to assist patients to either wash in their own beds or use facilities in other wards. Apart from this issue, the audit team also noted that, in a number of cases, though sanitary facilities would be available and generally clean, these were found to be in a significantly run-down and, in certain instances, completely unacceptable condition.

2.1.7. The audit team also observed a number of wards which, in its opinion, were more adequately sized for the number of patients they accommodated, though their space was inefficiently laid out. Specifically, the audit team noted how certain wards had a very large common area, possibly larger than required for the number of patients within, but still featured crammed dormitories, once again resulting in patients being afforded less than adequate personal space and privacy. In these instances, NAO also saw that the logistical

concerns as highlighted in section 2.1.2 above were further compounded due to the size of the ward, which forces nurses to cover a larger area in order to supervise all their patients.

2.1.8. During its visits, the audit team additionally noted accessibility concerns in at least two wards. Specifically, one ward accommodating geriatric patients only has access to the living/dining area through three steps, which was identified as a concern by the nurse in charge due to the mobility restrictions of the respective patients. In another instance, the audit team observed how a particular ward was made out of two floors with a lift connecting the upstairs dormitories to the ground floor common room. NAO was however informed that this lift was often not operational, thereby creating considerable challenges to staff given that some patients, due to their condition, find it significantly difficult to use stairs.

### NAO Observation

2.1.9. NAO once again draws attention to the fact that MCH is a 150-year-old building, constructed with the clinical and social mindset towards mental health of the time, rather than to cater for the requirements of modern mental health treatment. NAO here asserts that the building itself reinforces the prevalence of the negative stigma on mental health and the old socio-cultural approach towards this matter, as people suffering from such conditions are automatically associated with this outdated institution. Moreover, this Office is significantly concerned with the fact that the hospital's outdated and restrictive design (particularly due to aforementioned sizing and facilities issues) may be impinging on the smooth running of the institution's daily operations, further diluting the efficiency of MCH's staff and consequently the quality of service being provided to the patient.

## 2.2. Structural safety concerns in a number of MCH wards forces the relocation of patients to the detriment of their living conditions

2.2.1. In reading through this section one must keep in mind that the audit team did not, in any way, carry out professional structural integrity or any other technical studies on MCH premises and any opinions on this matter were solely based on visual observations. During the team's site visits however, a number of infrastructural related problems (presented hereunder) became manifestly obvious and immediately identifiable.

2.2.2. During this audit exercise, MCH officials highlighted that a number of wards were deemed as unsafe, so much so that patients had to be moved out to alternate locations as a precaution. Though the audit team was only present in MCH's wards for a relatively limited period of time (that is, during its fieldwork stage) and can therefore not vouch for the situation prior or after this period, it can here be reported that, during its visits, the team did not observe any patients being accommodated in MCH buildings which, upon basic visual inspection, seemed structurally unsafe.

2.2.3. This being said however, MCH staff informed the audit team that maintenance needs across MCH are generally identified by the nursing and caring staff, rather than by the maintenance department. Upon identification of any defects, a written request, through a formal Online Request System (ORS), is put forward to the maintenance team. It was however brought to NAO's attention that a number of these requests remain unaddressed for what is considered as an unacceptable period of time, with MCH personnel asserting that some cases remain pending for a number of years. During its inspections, the audit team did observe, on numerous occasions, signs of seemingly paused works-in-progress in a number of active wards (such as partly removed soffits, trenching and exposed plumbing) which, in themselves, may present health and safety risks to patients and staff. When queried about this, MCH management replied that difficulties prevail, especially when it comes to obtain the necessary materials for repairs. More specifically, the audit team was informed that there were occasions in which maintenance is hindered as the centralised procurement process adopted by the MFH is very time consuming. The audit team also gathered that there are occasions in which works would be initiated, only for MCH maintenance personnel to be redirected to other, more urgent interventions, thereby leaving the former project pending. During meetings with NAO, MCH officials highlighted the fact that, as at time of writing of this report, the position of Chief Operations Officer (COO) was vacant, and consequently the hospital is relying on its foremen to plan and execute necessary works. MCH management further admitted with the audit team that, though acting with the best of intentions, MCH maintenance personnel sometimes lacked good planning sense in this area, which would result in a task remaining as 'works-in-progress' for a longer time then strictly necessary, thereby prolonging exposure of safety risks to patients and staff. During meetings with NAO, MCH officials however further stated that long term planning in terms of infrastructural repairs and pro-active maintenance was very difficult, as new needs of an urgent nature emerge practically on a daily basis. This creates a situation in which long-term plans have to be constantly put on the back burner so that urgent issues may be addressed.

2.2.4. During its visits, this Office observed how a number of outdoor areas could not be utilised for patients' recreational purposes due to safety hazards which, in NAO's opinion, should not be too laborious or costly to rectify. In one particular instance, the audit team was shown a sizeable yard, with significant recreational potential, which was closed off to patients due to the presence of open trenches. When queried about this MCH management stated that these are in the pipeline, but could not give a satisfactory answer as to why these have been left unattended for so long.

2.2.5. NAO additionally observed that patients who were relocated due to structurally unsound wards could not always be afforded with a space which meets a dignified level of comfort. The audit team was informed that, with the hospital operating at full occupancy in most areas, MCH management had no option but to relocate these patients to areas which were not intended to serve as wards or alternatively accommodate these patients in other wards resulting in overcrowding.

2.2.6. It must also be noted, however, that during this exercise the audit team was informed that a number of wards underwent, or have recently undergone, significant refurbishment. Two wards that stood out were the Young People's Unit (YPU) and Male Ward 2. Nonetheless, these significant refurbishments were undertaken following initiatives by the Marigold Foundation, with MCH management then undertaking a more complete project. MCH officials also stated that the three wards encompassing the geriatric complex were refurbished by St. Vincent De Paul Residence (SVPR) rather than MCH itself.

2.2.7. While keeping these considerations in mind, NAO however does take note of the Health Minister's statement made in early 2018 which committed central government to invest some €30million over a period of five years so that MCH's structure is made safe. NAO enquired with MCH's Chief Executive Officer (CEO) on the details of this commitment, to which the latter replied that, as at time of writing of this report, even though this assurance was communicated to him verbally, no official written documentation on this had as yet been forwarded to him.

## NAO Observation

2.2.8. The significantly pressing infrastructural situation at MCH, brought about through years of neglect, reveals a lack of commitment and investment towards mental health by the relevant authorities so far. As will be discussed in Chapter 4, the annual recurrent budget allocated to MCH to date is inadequate to ascertain that the hospital is run optimally, let alone sufficient to address any significant infrastructural problems or, even more so, carry out any preventive maintenance. To this end, this Office believes that MCH management is very limited in what it can actuate before the materialisation of a strong commitment from central Government, both in terms of policy and a realistically adequate capital injection to rectify this situation.

2.2.9. NAO is also significantly concerned about the apparent lack of internal direction insofar as structural maintenance and repairs are concerned. Specifically, and especially in the face of such an obvious need for attention in this area, NAO does not understand how, as at time of this exercise, the position of COO has been vacant for an extended period. This situation, NAO opines, is greatly hindering the effective and efficient management of maintenance and repairs in MCH, while potentially impinging on the hospital's full potential, once again to the patients' detriment.

## 2.3. Overall ambience in a good number of MCH wards is a non-starter for the well-being and dignity of mental health patients

2.3.1. Though, as mentioned earlier, problems exist about the structural integrity of some of MCH's buildings, the audit team observed that a much more widespread concern prevails. Specifically, NAO noted that a good number of wards within MCH generally feature dismal ambience, mostly generated by the buildings' grossly outdated and inadequate finishings and furnishings.

2.3.2. During its site visits, NAO noted that a number of MCH wards were relatively well maintained. While the buildings themselves of such wards remain evidently old, the team noted that efforts were done to keep a relatively fresh and healthy feel to them with, for example, pleasantly coloured walls, curtains, pictures and inspirational messages (either hung or painted directly on walls). Of particular note, the audit team observed how one of the wards featured a display of a typical living room, including a fully set up dinner table, which was intended to exude a homely feeling to the patients.

2.3.3. This situation however is in complete reverse for a good number of other wards which, the audit team observed, were stripped down to the very bare essentials, and even these being haphazardly provided. Very old or no paint on walls, stained walls and floors, very old tiling, hand wash basins carelessly fixed at odd angles and a complete and utter absence of any soft furnishings or decor (such as curtains, pictures etc) were all observed by the audit team during conducted site visits. It is also worth noting that a good number of visits were carried out during the Christmas period, and the absolute absence of any festive decoration in any parts of these wards made this observation even more prominent. These considerations, coupled with the outdated design of the structure itself, make for truly appalling and unacceptable conditions both for the patients as well as for MCH staff.

2.3.4. It must here be highlighted that, having visited all MCH wards, the audit team observed a general correlation between the ambience of the ward and the gender of the nurses in charge. More specifically, this Office noted that wards managed by female staff which, as MCH practice dictates, are typically occupied by female patients, were generally better furnished and finished than those run (and therefore occupied) by males. When the audit team presented this observation to MCH management, namely that there did not seem to be a standard approach towards ward embellishments, the latter indicated that this situation has been duly noted but that there were many other issues that need attending to. This lack of standard approach towards the wards' ambience by MCH's management was confirmed by the nurses' responses during NAO's visits, with these informing the audit team that the embellishment of the better kept wards was solely due to their personal initiative and persistence.

### NAO Observation

2.3.5. Through its site visits, the audit team concluded that the negative ambience in a good number of the hospital's wards may be greatly impinging on the patients' and staff's dignity if not also mental wellbeing itself. To this end, while acknowledging that a hospital's environment (by its very nature) is difficult in this respect, NAO is concerned with the fact that MCH management does not seem committed to ensure that a minimum level of positive ambience is achieved throughout all its wards. NAO here once again draws attention to the observed correlation between the ward's ambience and the gender of nurses in charge. This observation, NAO opines, shows that MCH management does not adopt a standard approach to this issue nor does it actively manage it, but rather leaves this consideration up to the respective ward's personnel.

## 2.4. Recommendations

2.4.1. NAO is concerned with the situation in which the majority of mental health in-patients currently find themselves in. The structural degeneration of MCH throughout the years is not justifiable and this Office strongly feels that MCH in-patients deserve an immediate solution to these concerns. NAO here acknowledges that there is no easy solution to the challenges presented by MCH's outdated design, particularly due to cost and the historic value of the building itself. The most obvious solution to this problem would therefore be for Government to relocate the national mental health hub to a new building constructed according to modern standards and specifications. This, NAO opines, could also significantly dilute the mental health stigma which is partly associated with the MCH legacy. NAO also strongly recommends that adequate effort and resources should be invested in the current hospital even if as a stopgap measure, so that all mental health in-patients currently at MCH are afforded with a decent level of comfort and dignity. This Office here therefore asserts that, while it recognises the significant capital injection required to undergo such an initiative, this would be the most ideal solution.

2.4.2. If the above recommendation is deemed unfeasible, NAO strongly urges the relevant authorities and MCH management to invest the necessary resources as soon as possible towards making the hospital structurally secure so that mental health patients can receive their treatment safely. NAO also highly recommends that MCH management sets a minimum standard across all wards insofar as the hospital's ambience and accessibility are concerned, thereby ascertaining that all mental health in-patients are afforded with a decent and dignified environment. This, NAO further asserts, is to be done in a timely manner, which least effects mental health in-patients and which, in particular, avoids the phenomenon of overcrowding. Once this matter is tackled, NAO encourages MCH management to create, implement, and maintain a continuous maintenance programme so that the hospital would not revert to its current unacceptable state.

# Chapter 3

## MCH's Security Arrangements not fit for purpose

**This Chapter highlights NAO's observations on the security arrangements within MCH, namely on the security guard complement, its CCTV system, the management of the hospital's master keys and other security risks prevalent in MCH's physical structure.**

### 3.1. Security complement largely inadequate for MCH's needs

3.1.1. In view of the security requirements of any hospital, but especially those of a mental health institution, NAO sought to determine whether the security arrangements at MCH are adequate. To this end, the audit team enquired on the composition of the security complement at the hospital. To this, MCH management replied that, as at time of writing of this report, the security complement at MCH was made up of fifteen security personnel, with these being a mix of MCH employees and outsourced individuals. These are further assisted by a police officer who is stationed at the hospital's main gate during working hours. This complement covers all MCH premises bar the forensic units, which, though still physically forming part of the MCH complex, are essentially an extension of the Corradino Correctional Facility and consequently have a security detail from this latter institution and a security protocol of their own.

3.1.2. The audit team further enquired on what is the exact role of MCH's security personnel, and specifically if they can be called upon to physically restrain or search a patient or visitor if the situation so merits. This Office was informed that, bar the police officer (whose very office endows him with such powers) members of the security complement within MCH do not physically touch or restrain anyone. When queried why, MCH officials replied that the outsourced personnel deployed as security guards, in fact, are governed through a contract which procures services of telephone operators, receptionists, office assistants, general clerks as well as accounting and senior clerks. A cursory look at the contract governing this outsourced service in fact shows that the job description for these personnel is geared towards administrative rather than security duties. NAO was in fact further informed that, in view of this engagement, the deployed personnel refuse to carry out the "physical" duties (such as searches, restraint etc.) generally attributed with the security function. The audit team further enquired whether the same situation prevails with security personnel engaged directly with the hospital. To this, MCH management replied that these personnel also refuse to carry out such functions, citing that it is not their job, while threatening industrial action if pressured. A review of the job description of these officers by the audit team however did not, in any way, indicate that this function does not fall within their remit. Asked therefore what functions the MCH security complement is expected to carry

out, NAO was informed that these are generally tasked to conduct patrols, take note of cars coming in or going out of the hospital's premises, ascertain that all doors are closed and call for assistance in the event of an incident. MCH officials further stated that if a patient would need to be physically restrained, this responsibility falls on the nurses who have been specifically trained to handle this type of situation. The audit team was also informed that this security complement never attended de-escalation training which, as NAO was informed, was provided to most MCH staff.

3.1.3. During its site visits, the audit team also observed how it was never stopped at MCH's gates, and was never enquired about its presence on the hospital's premises. It was also noted that the barrier at the main gate intended at stopping cars from entering freely into MCH grounds was mostly left open. In fact, the audit team accessed MCH grounds by car multiple times without ever being challenged. It is here important to note that this entrance is intended solely for access by car, while pedestrians are supposed to access the premises through a small guardhouse at the side. NAO is however in a position to report that the audit team accessed the hospital's grounds by foot multiple times through the open-barrier car entrance, again without being questioned. This Office further observed how security was slightly tightened following the absconding of a patient in early February 2018. More specifically, NAO observed how, following this incident, the barrier was mostly found shut, and when attempting to access by foot through this barrier, the audit team was simply directed to pass through the aforementioned guardhouse. Nonetheless, this Office observed how this building was not always manned, and when it was, NAO officials still passed through with no questions asked. It is also worth mentioning that, on one occasion, an NAO official was given a visitors' tag but only upon the same official's request, while the other two audit team members simultaneously still accessed the grounds from the vehicle entrance unchecked. Furthermore, NAO is in a position to report that the audit team was never stopped or prompted at any point within MCH premises when not in possession of a visitor's tag nor were they ever searched for any irregular items.

3.1.4. Just as security concerns exist for people coming into the MCH premises, the audit team noted that the same could be said for anyone leaving them. Specifically, NAO saw that the security complement at the hospital have no means to effectively, and in a practical manner, identify patients from anyone else. This possibly precludes security personnel from taking any action should patients attempt to leave MCH grounds from the main gate against the consultants' instructions.

## NAO Observation

3.1.5. While a mental health hospital is not and should not be assimilated with a detention facility, its security requirements are more demanding than those of a general hospital. To this end, NAO is significantly concerned about the fact that the outsourced security complement at MCH is engaged through a contract which is designed to procure the services of administrative staff rather than security personnel. This in essence means that the hospital

is deploying clerks or staff holding similar grades to perform the duties of security personnel in an environment which, this Office opines, requires a particularly robust security function. Moreover, NAO cannot understand the situation of security personnel engaged directly with MCH refusing to carry out what this Office considers as necessary security functions within an operational environment such as that presented by this hospital. These concerns are reinforced with the apparent haphazard and generally slack approach by which security is applied at the main gate, as tested and reported by the audit team. These considerations, together with the fact that the security complement at MCH is not trained in de-escalation like the rest of the institution's staff, begs NAO to seriously question the adequacy of the MCH security complement.

## 3.2. Significant shortcomings prevail in MCH's CCTV system

3.2.1. From the conducted fieldwork, NAO noted that MCH does not make extensive use of Closed-Circuit Television (CCTV) cameras as a security measure within wards. In fact, during its inspections and through information forwarded by MCH management, the audit team noted that CCTV cameras were installed in Male Ward 8, Maintenance Stores, Young People's unit, Human Resources (HR) Offices, Female DDU, Female Ward 1, Sala Speranza, MSU, Canteen, Reception area, Centru Tommaso Chetcuti, SNO and the Accounts Offices. Despite having a CCTV camera installed however, this Office was further informed that a number of the hospital's cameras were not operational and that some wards only have one camera surveilling the main door thereby leaving the rest of the ward without coverage.

3.2.2. During meetings with NAO, MCH representatives also stated that different suppliers were involved in the acquisition of these cameras and consequently these operate individually rather than through a centralised system. Finally, NAO was also informed that the cameras at MCH are only utilised for post-incident evidence purposes rather than active monitoring, with nobody being assigned to oversee live footage.

### NAO Observation

3.2.3. It is this Office's considered opinion that CCTV cameras, if actively monitored, are a very effective and efficient means by which to address security requirements of any institution, with MCH being no different. To this end, NAO is concerned with how this tool is not being used more widely by this hospital, but rather utilised sparingly. This Office's concern is further compounded by the apparent lack of a standardised approach on the use of this tool throughout all of MCH's wards and by the fact that even the somewhat limited CCTV cameras in place throughout the premises are not all operational. These, shortcomings coupled with the facts that the cameras in place do not report to a centralised console and are not being actively monitored (but rather retrospectively referred to in the event of an incident), leads NAO to conclude that the potential of such a security system is being grossly underutilised by MCH, making it much easier for security gaps to prevail. NAO opines that such shortcomings in an environment like that of MCH is unacceptable given the extent of the consequences which may materialise due to this situation.

## 3.3. Insufficient controls on keys to MCH wards

3.3.1. NAO feels it is important to point out that during inspection visits, the audit team noted that at no point were any ward security doors found open. In fact, NAO observed how, during these visits, the accompanying officers and all other staff on duty, adhered religiously to the protocol of keeping ward doors locked at all times. Nonetheless, during meetings with MCH management, the audit team saw how the management and distribution of ward master keys do not fall under the responsibility of the security department but rather, this function was assigned to the Chief Nursing Manager (CNM). The audit team also gathered that these keys are rather widely distributed across staff, both directly engaged with the hospital and outsourced, and ranging from management to minor grades. The audit team was additionally informed that, while a number of these keys never make it out of MCH premises (particularly those assigned to cleaners as these are returned to designated offices), other personnel retain these keys at all times even when not on duty. The audit team also observed how the CNM retains a record of all personnel who were assigned such keys, but has no effective means to comprehensively track the keys' movement and utilisation.

### NAO Observation

3.3.2. NAO disagrees that the retention and management of keys, which give access to what this Office considers as very sensitive areas (particularly wards), is managed by the CNM. As discussed in Chapter 4, nurses are already a stretched resource and should therefore not be burdened by otherwise avoidable ancillary duties. This Office is also significantly concerned with the fact that there is no proper system in place by which the movement and utilisation of such keys are effectively monitored, especially when considering MCH's very sensitive operational environment and that this single key gives access to all the hospital's areas and wards.

## 3.4. Security risks evident in MCH's premises

3.4.1. NAO observed how the physical structure of MCH's outer grounds and that of some of its wards, may be creating security risks. As an example, the audit team was shown how Male Ward 7's outdoor recreational area had to be restricted to a smaller perimeter (by setting-up a metal fence) as the boundary wall is too low in some points, increasing the risk of unauthorised exit. The audit team was also informed that, in some areas, trees planted close to the MCH perimeter wall also create security concerns and need to be tended-to to mitigate the risk of patients absconding by utilising these as climbing aids. When queried why no more permanent measures have been taken in this regard, MCH representatives stated that suggestions to put up fencing to reduce such risks were dismissed citing aesthetic reasons. During meetings with NAO, MCH personnel also stated that a good number of the hospital's apertures are old and consequently weakened, which increases the risks of patients being able to pry these open .

### NAO Observation

3.4.2. The security deficiencies identified in MCH's perimeter present significant and obvious risks, much to NAO's concern. This consideration becomes even more pressing when one keeps in view the other security faults identified within the hospital, which further compound risks. NAO also asserts that these shortcomings may be strengthening the resolve of those in-patients intent on leaving the premises without authorisation, and consequently exposing them to the associated dangers of such an undertaking.

## 3.5. Recommendations

3.5.1. In view of the limitations prevalent in the MCH security staff complement, NAO recommends that a needs analysis is carried out to identify all the security requirements of the hospital, which among others include: tighter security at the main gate; relevant training; clearer and more comprehensive job descriptions; and outsourcing contracts which reflect the actual security needs of the hospital. Once these are seen to, NAO strongly urges the hospital's management to ascertain the deployment of a complement which is able and willing to satisfy all identified security requirements, including those which merit the physical element. It is important to stress that this recommendation applies to both the outsourced individuals as well as those directly engaged with the hospital.

3.5.2. The utilisation of a proper CCTV system contributes to increased efficiency and effectiveness in any security function. To this end, NAO recommends that MCH gives due attention to this area and adequately invests in this tool. This Office opines that more extensive use of CCTV can be adopted throughout the hospital, particularly in high-risk areas, so that security gaps are tightened and possibly reduce the need of a labour intensive approach. It is also imperative that MCH management ascertains that all of the installed cameras are operational and ideally able to interact through a central hub. In so doing, these could be easily and actively monitored by a member of the hospital's security staff complement rather than used only reactively.

3.5.3. NAO feels that the management and distribution of master keys, especially given that these provide access to what this Office considers as very sensitive areas (particularly certain high risk wards), is a security function which should be shouldered by a security department rather than the nursing staff. This Office also suggests that a system is introduced whereby master keys do not leave MCH premises. Specifically, it is recommended that any staff eligible to carry such keys collects these from a central station upon the start of his/her working day, returning them accordingly at the end. Notwithstanding this, NAO opines that, ideally, this system is completely revamped and an electronic access control solution across all MCH is introduced. In so doing, a record of who accessed which area is retained, while giving management a means of how to assign or restrict access to particular areas to each member of staff.

3.5.4. In view of the apparent risks presented by the security deficiencies in the hospital's perimeter, NAO urges MCH management to invest the necessary effort and resources so that security gaps in this regard are addressed at the earliest. In so doing, MCH management would be minimising the possibility of in-patients attempting to leave the premises without the necessary authorisation, particularly through precarious means.

# Chapter 4

## MCH in dire need of resources and an overall Strategic Plan

**This Chapter brings to the fore challenges being met by MCH insofar as financial (both recurrent and capital) and human resources are concerned. It also highlights the negative effects generated by the absence of an overall strategic plan.**

### 4.1. MCH's recurrent financial allocation is not sufficient to address the legacy of long standing shortcomings in Mental Health services

4.1.1. During meetings with MCH management, particularly the two CEOs incumbent during the progression of this exercise as well as the Clinical Chair, the audit team was informed that MCH is grossly under financed. Specifically, the audit team gathered that in order for this hospital to operate adequately, a recurrent annual allocation of around €55 million is required, yet the actual recurrent mental health allocation in Malta for 2018 amounts to just under €35 million.

4.1.2. This financial shortage is further compounded when one considers the significantly pressing infrastructural situation at MCH (as previously discussed in more detail in Chapter 2). Specifically, in the absence of a substantial capital investment to address this situation, this identified deficiency intensifies, as a portion of the already limited recurrent allocation of funds has to be dedicated to partially address the more urgent extensive repair requirements of MCH.

4.1.3. Reference is once again made to the Health Minister's statement issued in early 2018 which committed central government to invest some €30 million over a period of five years for the address of structural defects in MCH. While positively acknowledging this allocation, NAO however notes that no mention of an upward revision in the recurrent allocation was made in order to reinforce other areas such as human resources and the decentralisation of mental health towards the community.

4.1.4. Apart from the fact that, till time of writing of this report, the total recurrent allocation towards mental health remains low, NAO also saw instances in which the limited funds allocated to MCH are not utilised to their full potential by the hospital's management itself. In effect, this study established that a number of inefficiencies can be observed, such as in the management of the hospital's HR; the drive towards the decentralisation of mental health services to community care; and the fact that a very significant number of patients

currently at MCH do not strictly require hospitalisation in a mental health institution. These issues will be discussed in detail throughout the subsequent parts of this report.

### NAO Observation

4.1.5. The deficiency of financial resources towards mental health in Malta is evident through the extrapolated ratio between what is needed against what is actually being recurrently injected. NAO is however more concerned that not even this limited allocation can be fully utilised towards the mental health patient receiving the quality of service he/she deserves. In effect, the hospital's recurrent funds have to be also utilised to address critical infrastructural situations brought about by years of neglect. While NAO commends Government's stated pledge to inject funds in order to address MCH's capital requirements, it notes that if the budget for recurrent expenditure remains unchanged, it will still fall significantly short from what the hospital needs to operate smoothly. To this end, and as will be highlighted further throughout this report, this Office asserts that, should funds be solely allocated to make the hospital's building safe, while sidelining other pressing operational issues, the inefficiencies within MCH would still persist.

## 4.2. HR shortages and problematic relations prevail within MCH

4.2.1. During its analysis, it became manifestly clear to the audit team that staff shortages prevail across all professional grades within MCH. Amongst others, the number of deployed doctors, social workers and occupational therapists were all highlighted as being insufficient by the hospital's management, while the shortage in the nurses' complement was identified as the most pressing. Specifically, the audit team saw how MCH had a total nursing complement of 420, with the audit team being however informed that a further 233 nursing staff are required for the hospital to service its current patient complement adequately. This pressing situation has left the relieving pools for most professional grades depleted, with management having no option in the present circumstances, but to revert to overtime in order to try to achieve a sufficient medical complement. In addition, the audit team also gathered that, though general nurses are capable to carry out nursing functions within a mental health institution, psychiatric nurses are obviously preferred due to their specialisation in the field. It is to be noted, however, that psychiatric nurses at MCH are in somewhat short supply.

4.2.2. Furthermore, prevalent HR shortages were also observed in the hospital's administration and management structure. Of particular note, and amongst others, the audit team saw how the position of COO has been vacant for an extended period of time, while the pivotal position of the hospital's Almoner is being filled in by an outsourced clerk. Shortages in the finance department have also been identified, with MCH's FC highlighting that he does not have enough qualified personnel to assist him in carrying out this fundamental function within MCH.

4.2.3. Apart from the obvious factor of limited funds, NAO was informed that shortages in certain professions (particularly nurses and social workers) are also due to nation-wide limited supply and disadvantageous public service remuneration packages. Further compounding these difficulties, however, the hospital's management also contended and expressed its disappointment that MCH is not given the priority it deserves in the allocation of HR, with other entities within the public health sector generally taking preference.

4.2.4. During its fieldwork, the audit team also observed that apart from these external factors impinging on the hospital's HR function, significant internal difficulties also prevail. The most prominent of these became manifestly obvious to the audit team throughout its study, specifically that relations throughout all strata of MCH's management and staff complement are strained. During meetings and site visits, NAO observed how most of MCH's personnel work in silos, and at times with pronounced disgruntlement being expressed both vertically towards sub-ordinates or management, as well as horizontally across peers. This Office also saw how communication across MCH's staff complement is compromised, with personnel generally feeling that they are left to fend for themselves by management, with the latter contending that not enough information is reaching it from front-liners.

4.2.5. Throughout its review, the audit team's attention was drawn by MCH's management, that some MCH personnel adopt a militant approach towards industrial relations, which situation at times heavily impinges on the efficient and effective running of the hospital. Specifically, NAO was also informed that MCH management feels limited on how it can affect any required changes, especially those related to staff re-deployment, as significant resistance by the latter is generally exhibited. Members of the hospital's management additionally informed NAO that in some disputes, the staff's first point of contact would be the union rather than their respective line-manager. In view of this, MCH's management expressed that it would have to generally address any raised issues by first discussing these with the respective union and only promote discussions with the hospital's employees if or when said issues are resolved with the unions beforehand.

4.2.6. It was also brought to NAO's attention that, apart from outsourced personnel, nobody at MCH records one's attendance through an electronic attendance verification system. The audit team was also informed that, in the absence of a proper palming solution, MCH personnel register their attendance at work through outdated and very easily tempered-with systems, such as manual signing or punch cards.

4.2.7. Further compounding the immediately preceding point, MCH officials also pointed out to NAO that the hospital's staff is engaged to operate with different shift patterns. It is however important to highlight that the differences in a number of these shifts do not prevail as a result of the exigencies of the hospital, but rather due to the engagement agreement of each individual member of staff, which situation poses further logistical challenges to management. Asked why shifts are not changed so that they may be better aligned with the needs of the hospital, MCH officials once again cited the militant approach adopted by some of its employees.

4.2.8. By means of a final point on this matter, NAO feels it important to report on the generally low morale felt throughout MCH's staff. During meetings with MCH management and site visits with the hospital's personnel, the audit team observed a widespread sense of resignation to MCH's current situation, and an overall demoralised staff complement. In fact, NAO observed how most of the interviewed MCH personnel showed eagerness to voice their concerns to the audit team, indicating that such an opportunity for effective change is rarely made available to them. When delving into why this state of affairs prevails, the audit team gathered that the stagnant situation at MCH makes it very difficult for its employees to be motivated and energised towards their work, and that it is only their professional vocation and sense of duty towards the patients that provide the necessary drive for their everyday efforts.

## NAO Observations

4.2.9. Staff shortage in any institution obviously creates problems with strong negative repercussions. NAO however feels that this is more of a concern in the case of MCH, given the very sensitive nature of its operations and service users. The immediacy by which an incident can develop in this institution, and the significant consequences that it may generate, renders any staff shortage in MCH unacceptable, let alone one so extensive.

4.2.10. This Office is also deeply concerned about the apparent difficulties that prevail within the MCH staff complement which, amongst others, result in the identified silo approach. This situation, NAO notes, may be generating a vicious cycle in which, the more segregated the personnel get, the more pronounced the miscommunication becomes, which in turn reinforces the 'isolation' mentality. This state of affairs, NAO notes, only serves to dilute MCH's efficiency and effectiveness, which shortcomings are ultimately always transposed to a reduced quality of service being offered to the mental health patient.

4.2.11. The militant attitude adopted by some of MCH's staff complement towards industrial relations also raises significant concerns to NAO. As a start, this Office cannot understand the reasoning behind the fact of public service personnel refusing to record their attendance at work through a reliable electronic punching system. This practice creates very obvious risks of abuse and unnecessarily burdens the hospital's monitoring and administrative functions over its HR. NAO also cannot accept that the hospital's management feels constrained when it comes to making necessary changes to the deployment of its HR or streamlining shift patterns to facilitate service coverage throughout the institution. Notwithstanding this however, it is also of great concern to this Office that MCH staff feels it has to resort to trade unions as the primary point of contact to clarify or tackle any issue with the management, raising questions again on the quality of the rapport between the hospital's management and employees.

4.2.12. Finally, this Office feels it is obliged to express its disquiet at the general low morale of the MCH staff complement and the consequences that this may have on the same personnel.

In addition, while NAO strongly feels that any employed individual should be able to feel a sense of positivity and self-fulfilment from his/her employment, this Office is further concerned on the effect that a generally demoralised workforce could have on the quality of service being delivered to mental health patients.

## 4.3. No comprehensive strategic plan in place for Mental Health

4.3.1. During meetings with MCH's management, it became apparent that, as at time of writing of this report, no formal written comprehensive strategy for MCH's future was yet in place. Specifically, as already reported earlier, the CEO informed the audit team that his current direction by the Ministry, and consequently his current primary priority, is to see that MCH is made structurally safe. From its review, the audit team further gathered that MCH management is not aware of any other plans, particularly those regarding the further decentralisation of services towards community care and how to revamp the hospitals internal operations.

4.3.2. This Office also observed that the situation of having multiple changes in the hospital's CEO over a relatively short period of time did not provide a favourable foundation for any meaningful long term plan to be devised, implemented and seen through. Specifically, the audit team noted how, over the period of the past two years, three different individuals occupied this pivotal position, with the latest incumbent being deployed at the beginning of 2018. The lack of continuity generated by these changes was highlighted to the audit team by multiple interviewed individuals, with some expressing that this made them feel spent and without direction. NAO was further informed that this situation forces these individuals to repeatedly re-align their priorities, at times at the cost of not seeing initiatives through to their successful conclusion.

### NAO Observation

4.3.3. While the infrastructural situation at MCH is most pressing and requires immediate attention, NAO asserts that challenges surrounding this institution are much wider than just its physical building. To this end, NAO is concerned with the fact that MCH is yet to have a comprehensive strategy in place, which situation creates a vacuum in vision and direction for mental health. This Office is further concerned with the high CEO turnover during the past recent years, which further reinforces the aforementioned shortcoming.

## 4.4. Recommendations

4.4.1. The very dire financial situation at MCH, both on the recurrent as well as the capital expenditure side, calls for Government to put Mental Health higher on its agenda and commit the necessary financial investment to this area. Keeping in view Government's recent stated pledge on the capital front, NAO still strongly recommends that a detailed study is commissioned, involving technical professionals and front line personnel, so that

any funds invested are done so in the most efficient and cost-effective manner. Specifically, this Office strongly feels that a complete review of priorities is required so that any injected funds, apart from the clear need of making the hospital structurally safe, would contribute towards tackling internal operational issues and consequently improving the provision of mental health services. This, NAO opines, would limit the need of mental health patients being admitted to the hospital or, if admitted, reduce as much as possible the time required as an in-patient. Such an outcome would in turn further relieve financial stresses exerted on the national health budget.

4.4.2. In view of the significant repercussions that staff shortage may have in an institution such as MCH, NAO urges the hospital's management to relentlessly present its case and exert continuous pressure through the appropriate channels so that this situation is rectified at the earliest. Should this not prove successful, this Office recommends that the hospital's management explores other alternatives, such as extending outsourcing agreements as necessary to address the most pressing staff shortages.

4.4.3. While recognising that the causes for the breakdown of communication between MCH management and its staff may be bi-directional, this Office puts the onus on MCH's management to invest the necessary effort and attention in rectifying this situation, particularly by stimulating inter-departmental communication and consequently eliminating the prevailing silo mentality. NAO also opines that, in so doing, MCH management would start paving the way to dilute the militant approach adopted by a significant segment of its personnel. This Office feels that if a healthier relationship between the hospital's management and its staff is achieved, more client-oriented decisions could be taken and a smoother operational environment achieved. This Office also points out that, as a result of this, better collaboration between MCH staff and management towards the attainment of common objectives would be incentivised while the general heavy disposition within the MCH staff complement would also be mitigated. This would result in a healthier working environment both for the hospital's employees and the patients alike.

4.4.4. The need for a concrete and all-encompassing formal written strategic plan of action for MCH is manifestly clear. This Office therefore urges Government to invest the necessary time and resources so that this is designed with the involvement of technical and qualified personnel at the earliest. Once this is achieved, it is of paramount importance that the final product is implemented as seamlessly as possible, causing the least disruption possible to the hospital's operations. NAO also strongly feels that a stable top management within this institution is pivotal so that any plans for the betterment of MCH could be seen through to their successful conclusion.

# Chapter 5

## A significant number of MCH's in-patients do not require hospitalisation in a Mental Health Institution

**This Chapter presents NAO's observations on how a significant number of beds in MCH are being occupied by individuals who do not require hospitalisation within a mental health institution, particularly among those classified as geriatric persons, substance abusers and institutionalised patients.**

### 5.1. MCH serving as a 'place of last resort' to a significant number of persons

5.1.1. When conducting site visits in all MCH wards, it became apparent to the audit team that a significant number of persons housed within (though possibly needing mental health care services to varying degrees), do not strictly require hospitalisation in a mental health institution. As will become evident in the following parts of this section, however, MCH still serves as a 'place of last resort' to a good number of individuals who would not have fitted in anywhere else including, amongst others, those who became an overspill of other institutions operating at more than full capacity; those who would not have fitted-in any other services provided by Government or local NGOs; and those who have become institutionalised.

*A significant number of MCH beds are occupied by geriatric residents who are not assigned to a Psychiatric Consultant*

5.1.2. During its fieldwork, NAO observed that three of MCH's wards were, as at time of writing of this report, housing 97 individuals who are geriatric persons in need of mainstream homing, caring and nursing services. NAO was further informed that, while some of these persons may have mental health problems, these would generally be issues which are normally associated with advanced age and which any normal home for the elderly should be geared to manage. Upon enquiry, the audit team gathered that these individuals are an overspill from the fully occupied SVPR, so much so that they are generally not assigned to any of MCH's psychiatric consultants. Notwithstanding this, however, NAO was informed by MCH officials that nursing, caring and homing services for these long-term residents are still being provided by the hospital and therefore billed on the already stretched MCH finances.

*A number of MCH beds occupied by persons with substance abuse as their primary problem*

5.1.3. During meetings with MCH personnel NAO was informed that substance abuse and mental health problems can often be interlinked, with one leading to the other or vice versa . In this regard, NAO saw how MCH caters for what it refers to as dual diagnosis, which provides for individuals who would be suffering from both a mental health condition and substance abuse problems. In fact, the audit team saw how the hospital dedicates two distinct wards for these, one for male patients and the other for females. This Office however also saw how an additional ward had to be created for male substance abusers whose behaviour could be considered as particularly problematic (namely Ward 8B). Specifically, the audit team was informed that these individuals display significantly bad behavioural issues and show no intention whatsoever to do anything about their substance abuse problem. NAO feels it important to stress that this situation was highlighted as a major concern by multiple members of MCH staff and management, including the CEO, Clinical Chair and Nursing Director. In fact, MCH officials highlighted how the hospital has to recurrently absorb these individuals since they repeatedly fall out of rehabilitation programmes provided by NGOs. The CNM expressed that these programmes may be proving to be too rigid for such individuals in terms of behavioural requirements, resulting in them being dismissed for non-compliance and therefore not completing their rehabilitation programme. NAO was informed that, following this dismissal, it is not uncommon for such individuals to turn to MCH for homing, threatening self-harm or suicide to ensure admission. Asked by the audit team whether such a threat would be genuine, the Clinical Chair replied that even if doubts would prevail, any medical practitioner cannot dismiss such a claim and would therefore have no option but to admit or refer these individuals for admission to MCH. It is here important to point out that any social benefits received by mental health patients are not forfeited upon admission to the hospital, with the exception of the previously mentioned geriatric persons (point 5.1.2 refers). Multiple MCH officials have highlighted that this practice may be incentivising individuals to seek admittance to MCH even though they do not strictly need the services of a mental health institution, with particular reference being made to the individuals in Ward 8B.

5.1.4. The Clinical Chair further highlighted that, once admitted, it is not always easy to discharge these individuals even when deemed fit, as some would once again revert to threatening self-harm. The Clinical Chair however also pointed out that, while this situation may not be ideal, MCH is essentially serving as a final safety net both for these persons and for society. Specifically he asserted that having these individuals admitted to MCH means that they are being kept in a controlled environment rather than becoming homeless or allowed to carry on with substance abuse within the community, while also precluding them from potentially committing other criminal activity.

### *MCH houses a significant number of institutionalised patients*

5.1.5. In its review, NAO also observed how a number of MCH in-patients have, for one reason or another, been residing in the hospital for an excessively long period of time, so much so that they have now become institutionalised. While a number of in-patients require lengthy hospitalisation due to their mental health condition, there are others who, with the right support, may have been clinically fit to function within the community, yet still reside at MCH. The audit team was informed that some of these latter individuals were admitted to the hospital when psychiatry was not as developed as it presently is, and have, over the years, become caught in a faulty system precluding them from being reintegrated within the community. This situation has greatly contributed to the significant erosion of these individuals' basic social skills, rendering them even more dependent on continuous assistance. This Office was further informed that a number of these individuals have become so institutionalised that it is now deemed unsafe for them to live outside of MCH.

### NAO Observation

5.1.6. While this Office does not contend that the individuals mentioned in this section are in need of targeted services, it however argues that they may not require hospitalisation in a mental health institution. As highlighted in other parts of this report, MCH is significantly strained in terms of space and resources. In view of this, NAO strongly feels that having these persons needlessly hospitalised within MCH, further compounds this pressing situation to the detriment of persons who strictly do require hospitalisation in a mental health institution. Additionally, in view of the fact that (with the exception of the aforementioned geriatric persons) social benefits are not withheld from anyone who is using MCH simply for homing services, NAO is concerned that there may be no real, effective disincentive for anyone who could be abusing the system. Finally, this Office also opines that the situation presented in this Chapter reflects nation-wide failures in the local support services system, both within the mental health environment as well as other sectors, with MCH having to serve as a final place of refuge for individuals who are not being supported anywhere else or are refusing other available services.

## 5.2. Recommendation

5.2.1. NAO recommends that an extensive clinical review is carried out so that individuals currently residing within MCH are assessed and categorised between those who strictly require hospitalisation in a mental health institution and those who do not. Following the identification of the latter, NAO strongly urges MCH management to spearhead an initiative in which a comprehensive action plan is devised in collaboration with other entities (both governmental and non-governmental), so that those individuals determined as not requiring hospitalisation within MCH are provided with better targeted care, assistance and support out of the hospital. NAO acknowledges the magnitude of this initiative and notes that it can only materialise through a strong commitment from central Government to address prevailing gaps in the country's support structure. If successful however, NAO notes that such an initiative would relieve significant stress from MCH's strained resources, allowing management to focus and be better directed towards the hospital's pressing requirements.

# Chapter 6

## MCH's Community Services still far from ideal

**This Chapter presents the main challenges being faced by community mental health clinics and day centres and how these are affecting the quality of service being offered to mental health outpatients.**

### 6.1. Community Services are under resourced and feel detached from MCH

6.1.1. During its review, NAO saw how MCH's community care element can be classified into two broad categories, namely community clinics and day centres. While the community clinics are mainly geared towards seeing to the outpatients' clinical requirements, the day centres are intended to assist mental health patients in their rehabilitation to live within the community, mainly through occupational therapy. During its visits to these satellites, NAO gathered that MCH's ten community clinics currently offer services to approximately 11,500 outpatients, while the five day centres work with approximately 250 service users. Figure 2 presents the catchment areas covered by every respective clinic. It is worth noting that the catchment areas of the day centres are the same as those of the clinics, even if certain gaps in this latter service prevails (point 6.1.10 refers).

6.1.2. The role of the mental health community clinics can also be classified into two, namely as a first point of contact for new cases, as well as an outpatient follow-up for persons who have been discharged from MCH. On the other hand, the community day centres do not serve as a first point of contact but are only geared towards the rehabilitation of patients who have been referred by mental health clinics or MCH.

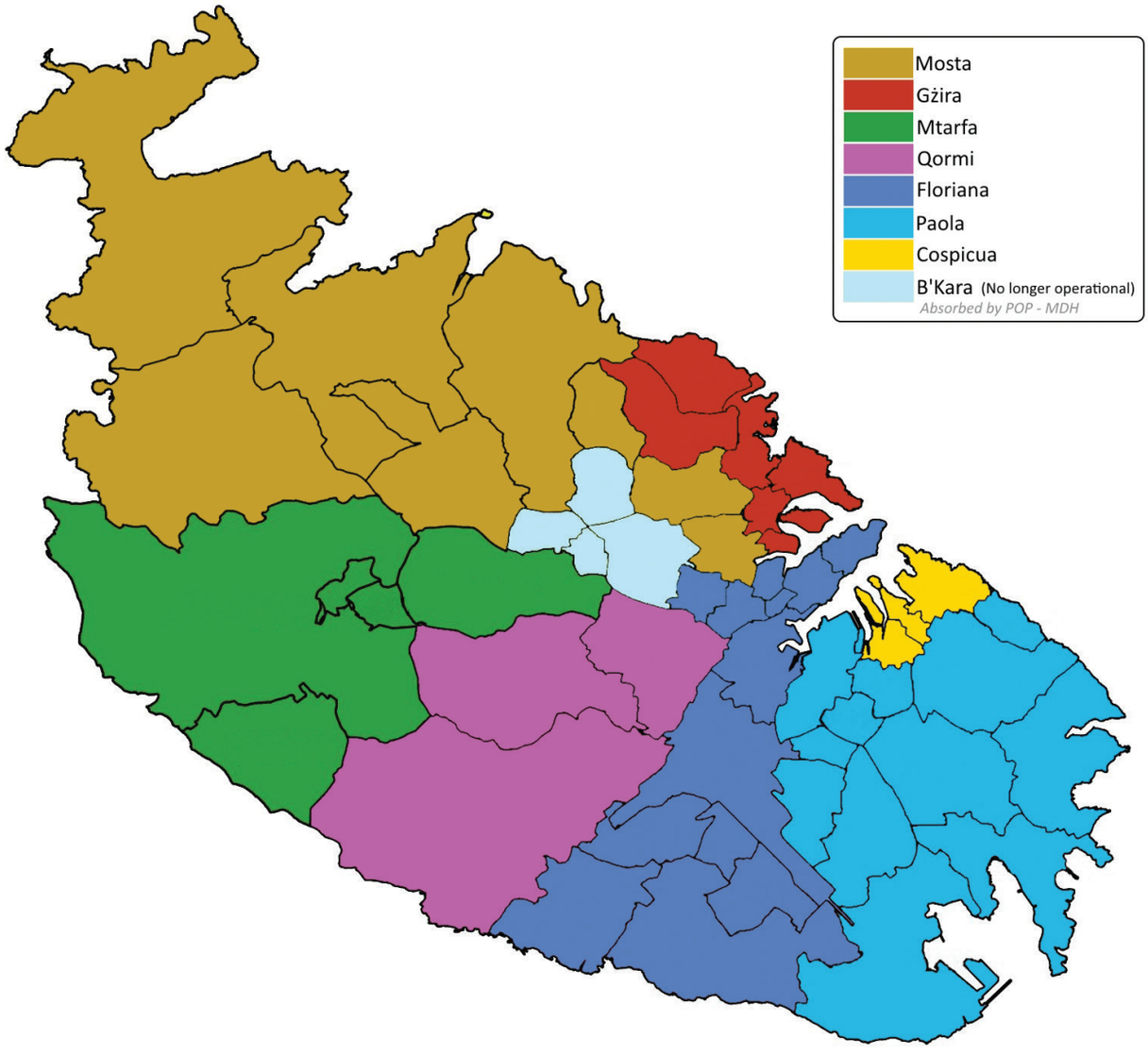
*MCH Satellite Clinics and Centres are generally understaffed*

6.1.3. Throughout its inspection visits, the audit team saw how both the mental health clinics and the MCH day centres are generally under-resourced particularly insofar as nurses are concerned. Given that no relieving pool exists, NAO observed how this situation causes significant logistical challenges, particularly in cases where home visits are required, in the event of emergencies and when staff vacation, sick or maternity leave is availed of. The audit team was informed that, on occasions and depending on the nature of the case, these challenges may lead to mental health clinics being closed, or home visits being postponed so that the limited human resources can be directed to the most pressing needs. Staff

shortages were also prevalent in the case of day centres, with officials expressing to NAO that more professional staff, particularly social workers and occupational therapists, are required so that a better rehabilitation programme is delivered to their service users.

6.1.4. Furthermore, NAO gathered that there is also a widespread shortage of support/ administrative personnel (such as clerks) within these community satellites. This situation, NAO was informed, leads to MCH's professional personnel (be it nurses, occupational therapists or social workers) having to allocate some of their hours for administrative tasks, further limiting their already stretched time allocation with their service-users.

Figure 2 - Community Clinics Catchment Areas



*Community clinics and centres generally have inadequate operating facilities, very limited maintenance and poor security arrangements*

6.1.5. MCH's community satellites are generally housed either within government premises (mainly: health centres; MDH; St Luke's Hospital and; MCH itself) or rented out from private parties. A general widespread concern that emerged from the conducted site visits however highlighted the limited or inadequate space within which these have to operate. When enquiring if this situation is being addressed, the audit team was informed that properties which are fit for purpose and which fall within the set rental budget are very difficult to find. During its visits, the audit team also saw how a number of these community satellites are not adequately equipped with IT facilities, observing that it is not uncommon for a community satellite to have a very limited number of computers, forcing staff to take turns in using such basic equipment. In addition, community officials also complained about connectivity issues, with some asserting that they do not have any access to the Government electronic portal and have to physically go to MCH to log information.

6.1.6. During the conducted visits, another common concern emerged, namely that these sites faced considerable difficulty when it came to premises maintenance. While the audit team observed that these premises were generally in a much better state than MCH itself, it was informed, by a good number of community officials, that works requested to be carried out by the hospital's maintenance department (particularly those requested by clinics or centres operating from rented properties and from St. Luke's Hospital), were left pending for an excessively long period of time. Community officials further highlighted that at times, when MCH maintenance personnel did eventually turn up, they were not properly equipped to carry out the requested works, on occasions even asking the community officials to provide them with basic tools or material. NAO was additionally informed that this situation has driven some community officials to carry out basic maintenance works themselves, or having to resort to their relatives or even the service users to tend to these needs. It is however important to note that this situation generally does not prevail in community sites operating within the premises of primary health centres and MDH, as any maintenance needs required would be addressed by the latter entities respectively.

6.1.7. Insofar as security arrangements are concerned, the audit team saw that none of the visited sites had a dedicated security complement. Instead, it was observed that some of the community units make use of panic buttons or the phone to communicate with other physically adjoining community satellites or health centres to request assistance in the event of a security incident. On the other hand, the remaining community sites, which do not have other MCH satellites in their immediate vicinity, do not have such arrangements and rely on conventional police intervention if the need arises. Additionally, a number of community sites expressed with NAO the need for intercoms for security purposes, and the fact that, as NAO was informed, these were never provided by MCH as they were deemed too costly.

### *Significant waiting lists prevail in most community satellites*

6.1.8. During this study, NAO found that two community day centres do not currently have a waiting list, with one of these further asserting that it currently has vacant places for additional service-users. NAO however noted that the remaining day centres and all of the mental health community clinics do have waiting lists. Specifically, NAO observed that an average waiting period of five months prevails from the date of first contact to the date set for a first appointment with a psychiatric consultant in the case of clinics or, for admission to a rehabilitation programme in the case of day centres. This Office however feels it pertinent to point out that the Children and Young People's Services' (CYPS) waiting list is by far the most severe. Specifically, the official in charge of this community clinic stated that a waiting period of between one to two years exists for non-urgent therapy, with urgent cases (including self-harming, overdosing and suicidal minors) having to wait four to six months for an appointment.

6.1.9. When queried why such significant waiting periods prevail, community clinics responded that not all psychiatric consultants and their teams are in a position to carry out frequent sessions in any one clinic. In fact, the audit team was informed that consultants or their teams hold sessions at a frequency ranging between once a week to once every six weeks in any one community clinic. On the other hand, representatives from day centres highlighted to NAO that the duration of a rehabilitation programme may vary, on occasions taking longer than originally planned due to the lower than expected level of responsiveness of some service-users. This, NAO was informed, may slow down the flow of service-user turnover in these rehabilitation centres. These considerations, together with the aforementioned lack of human resources and adequate operational space, greatly hinder the successful address of waiting lists within community satellites.

### *Gaps in community support prevail, limiting the provision of a comprehensive service*

6.1.10. As indicated multiple times by various MCH community officials, the northern segment of Malta is not adequately covered by community services . Specifically, insofar as community clinics are concerned, these are set up in Paola, Cospicua, Qormi, Floriana, MDH, Gzira, St. Luke's Hospital, MCH itself, Mtarfa and the northernmost in Mosta. NAO however saw that the Mosta community clinic is not a fully fledged clinic like others and, in fact, is considered a roaming clinic together with that of Gzira. This essentially means that the staff complement of these clinics has to be shared, and therefore has its time apportioned between these two locations. This consideration becomes particularly pressing when one considers that this complement is one of the smallest in size, practically comprising of only one full time nurse and a retired nurse working on part-time basis. The lack of coverage of the northern segment of the country also prevails in community day centres, as these are set up in Zejtun, Cospicua, Qormi, Paola and Floriana and having the same catchment areas as the clinics. This means that the catchment areas of the Mosta, Gzira and Mtarfa clinics are not covered by any service of a day centre with MCH officials noting that urgent cases are usually taken up by other day centres.

6.1.11. Community day centre officials informed NAO that the term 'day centre' is somewhat of a misnomer, as these sites are geared towards rehabilitation of service users to reintegrate them within the community rather than a social gathering place. In fact, community day centre officials strongly opine that this term should be changed to better reflect the work being done at these centres. Notwithstanding however, community officials explained that the 'day centre' social function is still very important so that a stable mental health state is maintained. In the absence of such a function and in the event that service-users do not manage to find any other alternate social outlet, there is an increased risk of deterioration in their mental health condition. NAO was however informed that, at present, no such specifically targeted service exists for mental health service-users in Malta.

6.1.12. During the audit team's visit, the CYPS representative asserted that a number of its service users exhibit significant conduct issues, including oppositional defiance, rather than mental health issues. In view of this, the CYPS representative stated that such individuals would benefit more from other targeted services, such as a boot camp, rather than a mental health community clinic. In view of the lack of such services locally however, such youths find themselves at CYPS, which situation, NAO notes, echoes that of MCH as discussed in Chapter 5.

### *Community satellites feel they are generally left to fend by themselves*

6.1.13. When visiting community clinics and day centres, the audit team came across a common voiced concern, specifically that these satellites feel that they are detached from MCH and generally left to fend for themselves. In particular, community officials asserted that effective communication between them and MCH is severely lacking, with any vision that MCH might have not being effectively conveyed and thereby leaving them generally without a sense of direction. In fact, community officials expressed that while MCH is often unjustly perceived as 'second-class' when compared to the rest of the health sector, they themselves feel second to MCH.

6.1.14. Despite this situation, however, NAO was informed that officials in community satellites (particularly day centres) are significantly self-driven and take several personal initiatives. In fact, the audit team was informed that these sites are in close communication with each other and work together to organise programmes and events to better facilitate their service-users' rehabilitation into the community.

## NAO Observation

6.1.15. The considerations presented in this Chapter heavily reflect on the priority, or lack thereof, being given to the mental health community services in Malta. NAO opines that these satellites do not carry the same stigma normally associated with MCH, which in-turn better positions them to incentivise people to approach them and seek necessary assistance.

Despite this however, the lack of direction and the detachment from MCH still means that the full potential of these satellites is not being attained. This situation limits the extent to which community services satisfy one of their core functions, namely to relieve burden from the central hospital by reducing the cases requiring admission to MCH. NAO makes particular reference to the Mental Health Commissioner's comments that the "mainstay of care must be community based" and repeated statements by the Health Ministry that the future of mental health resides in the further development of community services. While in agreement with these statements, this Office is still concerned with the fact that, if a drive towards promoting community services is undertaken, these are not sufficiently resourced nor well equipped to handle an increased demand. Despite this however, the lack of direction and the pronounced feeling of detachment from MCH still means that the full potential of these satellites is not being attained. This situation limits the extent to which community services satisfy one of their core functions, namely to relieve burden from the central hospital by reducing the cases requiring admission to MCH. Notwithstanding this however, NAO is concerned with the fact that, if a drive towards promoting community services is undertaken, these are not sufficiently resourced nor well equipped to handle an increased demand.

## 6.2. Recommendation

6.2.1. NAO opines that highly efficient and effective community services are the key for a substantial positive change in the mental health landscape in Malta. Being located within the community throughout the country and generally not falling under the long shadow of MCH's stigma, these satellites are best positioned to keep close contact with existing outpatients and serve as prompt first responders to new cases. NAO opines that this practice is essential so that mental health patients are treated and supported within the community, thereby decreasing the incidence of admissions into MCH, thus relieving financial, human resource and capacity stresses from the hospital. In view of this pivotal role, NAO strongly recommends that MCH management puts the strengthening of these community sites high on its agenda, primarily by adequately resourcing them (mainly through increased human resources, operating space and additional sites where needed) and using community services to spearhead Mental Health Malta's plans for the future.

# Concluding Remark

This review has shown that MCH, and by implication mental health in Malta, are still considered as secondary priority when compared to the rest of the local public health sector. This Office commends Government's recent commitment to invest some €30million to carry out much needed and long overdue repairs to MCH's physical premises, which would see to the address of the unacceptable structural condition this hospital currently finds itself in. NAO however strongly opines that the hospital's structural problems comprise but a portion of the challenges that MCH faces in its operations, and consequently a more holistic approach is required.

Being a mental health institution, MCH has to absorb a stigma which, unfortunately but generally, surrounds the type of health conditions it deals with. Decades of neglect and manifest lack of commitment by central government towards this area have however accentuated this concern, transforming an already challenging situation for the mental health patient to one even more difficult. As seen throughout this study, MCH is severely under resourced, both in terms of finance and human resources, while also facing considerable internal challenges. NAO is particularly concerned on: the generally strained relations between MCH's management and its staff; the hospital's inadequate security arrangements; the fact that MCH is partially serving as a place of last resort to individuals who (though possibly in need of assistance and other targeted services) do not require hospitalisation in a mental health institution and; the lack of drive towards community based services. These considerations, NAO opines, are exerting further unnecessary pressures on already stretched resources to the detriment of mental health patients, and strengthening the misplaced and lowly perception by which MCH is generally regarded.

In view of this, a comprehensive, focused and clear vision needs to be set for mental health in Malta. NAO opines that an all-encompassing national strategy on mental health needs to be implemented at the earliest to ensure the effective overhaul of MCH and to address the prevalent related negative stigma on mental health. In this regard, this Office feels it cannot emphasise enough the importance of an effective and efficient system of community-based services. In fact, NAO strongly recommends that any future mental health strategy should have community services as its flagship. These services, NAO asserts, are instrumental to reduce the burden from the central hospital particularly by: reaching out more to potential new cases; detecting early symptoms of mental health problems; providing early interventions; and following up on patients' progress within the community. NAO also feels that, with a strong community based system, hospitalisation in a mental health institution would become only a requirement for the most clinically acute cases. By implication, such a system would significantly reduce the impact on the national health bill, while ascertaining that, when possible, mental health patients remain integrated within the community and valuable contributors to society.

Notwithstanding the above considerations, NAO feels it essential to acknowledge that invaluable work is still being carried out on a daily basis with mental health patients throughout the country. This consideration makes this report's observations even more pertinent so that the good effort being undertaken in this respect is rewarded with a more focused, efficient and effective mental health system.

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