

# Maltese Association of Psychiatry

## **2018 Report on Staffing Levels in Malta's NHS, and Comparison with Recommended Standards**

November 2018



In May 2018, the Maltese Association of Psychiatry (MAP) was instructed by the Minister for Health Hon Fearne to describe the standards related to the current mental health service provision within Malta's National Health Service (NHS). This first report will focus on the medical manpower looking at the numbers of psychiatrists that are employed within our NHS and benchmark their workloads with the work carried out by psychiatrists within other developed countries.

### **Why is such a report necessary?**

Mental disorders are a major cause of ill health, in young people (YP) (WHO, 2009). The economic impact of poor mental health is estimated to be over £100 billion to the economy each year in England alone (Bhugra 2012). The UK spends more on mental health services than on any other area of health (Bhugra 2012). Of those aged up to 18 years one in ten have a mental disorder but only half access services and only a fifth specialist child and adolescents mental health services (CAMHS) (Ford, Goodman, & Meltezer, 1999). The burden of disease increases by 2.5 times between the ages of 10 to 14 years and 19 to 24 years (Gore et al., 2011). Of adult mental disorders, 75% emerge before the age of 25 years (Royal College of Paediatrics and Child Health, 2003). Around 1 in 5 mothers develop a mental disorder during pregnancy or within 1 year of child birth. Around 1 in 6 adults develop a common mental disorder during their lifetime, whilst 1 to 2% have a severe and enduring mental disorder. The prevalence rates of substance misuse in 18 to 24 year olds is reported to be 14% (ESPAD, 2015). The prevalence rates for people developing Dementia in Malta is between 1-2%, whilst the current Maltese population over 65 years is 18%. Hence, timely and successful access to mental health services in adolescence and adulthood is a public health priority (Davies, 2013; NICE, 2016).

### **Rationale for this report**

In producing this report, MAP wish to recognize the significant work undertaken by other organizations- for example the Alliance for Mental Health (A4MH) and the President's forum to name but a few who have helped raise public awareness of mental health issues. These organizations have all served to increase public health awareness and led to the recognition of the significant unmet need in the support of individuals with mental disorders. They all highlighted the urgent need to destigmatize mental illness and other mental disorders. All the subspecialties in psychiatry have contributed to this report to further raise public health awareness on the current state of Mental Health services and medical service provision in Malta. This report documents the current staffing level situation in mental health services and describes the need to provide a mental health service fit for purpose and able to meet the challenges of the 21st century.

Though this report focuses on medical man power, MAP is very conscious that other disciplines working in mental health have similar challenges. MAP has been meeting up with other professionals who work within the multidisciplinary team to share their provisional findings whilst encouraging each of the allied health professionals to undertake a similar exercise to identify their current staffing and describe their unmet needs. This work will be a basis for developing a comprehensive and multidisciplinary national health strategy to meet the mental health needs of service users in Malta and Gozo.

The data referred to in this report derives from the 2017 annual reports on adult and child mental health drawn up by Mental Health Malta. MAP is however concerned about the accuracy of the data currently available and the lack of any meaningful epidemiological data on mental health in Malta. MAP believes that there needs to be a significant improvement in the mental health data collection before it can be usefully employed to inform a mental health strategy and service development plan.

Despite these limitations, MAP would like to acknowledge the encouragement and support from the Minister for Health, and the Chief Medical Officer. They have been accessible and encouraged us to undertake these exercises.

### **The MAP suggestions for the Malta Mental Health Strategy**

We believe that both the Ministry of Health and the Mount Carmel Hospital (MCH) Management agree that Mount Carmel Hospital, from where mental health care is delivered is not fit for purpose and not of a standard expected for delivery of mental health services in a developed country. It is also of note that according to Eurostat and the World Health Organization (WHO), the number of psychiatrists per capita in Malta is the lowest in Europe, whilst the number of patients reviewed per psychiatrist per year is one of the highest. This in a service where other professionals working in mental health are also stretched. This would suggest an excessive workload for psychiatrists making it difficult for them to provide a safe and effective service for patients and poses a high risk of early burn out.

MAP completely supports the plans to phase out Mount Carmel Hospital which is unsafe and in a dilapidated state and develop a new acute psychiatric hospital which is conducive to the delivery of high quality mental health care. All modern mental health services are developed to ensure parity with physical health services and reduce stigmatisation. The overlap between mental and physical health is increasingly being recognised and the in-patient base of modern mental health services are co-located with physical health services. The new mental health provision should therefore be located within or physically connected to Mater Dei Hospital in Malta.

WHO has recently published that the combined rate of psychiatric beds per 100,000 population in community psychiatric in patients units, units in district hospitals and mental health hospital ranges from 185 in Malta (being the highest) to 8 in Italy (being the lowest) with an median rate of 72 beds per 100,000 population in Europe. Therefore, it must be recognised that modern mental health services are increasingly being delivered within the community and therefore though the development of a new hospital is essential and welcomed, in order for Malta to have a modern mental health service, there needs to be parallel urgent attention given to developing and enhancing community mental health services. MAP is strongly of the opinion that there needs to be an urgent shift in the mental health budget from in-patient services to community-based services. MAP advocates the development of a national mental health strategy encompassing both the development of the new acute inpatient base as well as the development of community mental health services across all ages from children, adolescents, adults and the elderly; covering all specialties including psychiatry of addictions and forensic psychiatry. The mental health strategy needs to involve third sector providers and needs to be able to provide a wide range of community services including assertive outreach, home based treatment, early intervention and services to support patient with complex and enduring mental disorders.

[infomapsych@gmail.com](mailto:infomapsych@gmail.com)

MAP believes that for any mental health strategy to be implemented and to be sustainable it requires significant focus on the workforce. This implies, not only the workforce of medical staff but that of all other professionals working in mental health. Providing opportunities for training and for professionals to specialize is likely to attract staff to work within the national health service in mental health and provide an incentive for them to continue to work in the public sector rather than this acting as a stepping stone for private practice.

Simply building a new hospital is not enough to support the development of a modern mental health service. Nor is it enough to tackle the change of culture required to motivate staff to work in mental health and stop the brain drain of talented staff from our independently funded mental health services.



Nigel Camilleri,  
President

### **Endorsement from the Alliance for Mental Health (A4MH)**

The Alliance for Mental Health (A4MH) have reviewed this document and approves that this is in line with the position paper the Alliance published in October 2016, which focuses on the developing needs of the mental health services in Malta. The need to increase the work force, not only of the medical staff, but also of nursing, social work, occupational therapists and psychologists remains one of the most pressing needs that the services have to address. Having a robust strategy to deal with this shortcoming is essential for the mental health services to function as proposed in the position paper and in this document.

## Summary

The Maltese Association of Psychiatry propose the following:

1. More consultant psychiatrists should be appointed, to reach 50-60 consultants. Of these, 23 should be community-based, 7 in-patient based, 9 for child and adolescent services, and further for old age, addictions, forensic, liaison and other sub-specialities. Resources need to be increased to meet service needs and thus increase quality of standards.
2. Job plans should follow recommended standards with appropriate and recommended work-loads that also allocate time for administration, management and continued professional development; and with adequate supervision to prevent burn-out.
3. The focus of the Malta Mental Health Strategy needs to shift the in-patient budget towards to the community services. With immediate attention given to the setting up of the Community Mental Health Teams (currently only 5 out of 9 sectors are covered – therefore there is clear inequity and difference in access to care between sectors). The MAP endorses the last budget plan which aims to develop a community based mental health service in the north of Malta. However the MAP identifies the lacunae of other services that provide an alternative to hospital admissions and these include; Home Based Treatment Teams, Assertive Outreach and Early Intervention in Psychosis Teams.
4. More administrative support for consultants is needed to ensure a smoothly and more efficient functioning of their diaries to provide clinical work and the development of specialist skills and knowledge. This would support consultants in meeting their clinical and academic standards, that could be stipulated by a re-validation process.
5. The staffing within the multi-disciplinary teams in the community mental health services need to be adequately staffed. Specifically addressing the severe shortage of psychologists and social workers within services. Appropriate numbers in staff will ensure that the service provision reaches standards set out by WHO and other EU recommendations.
6. The ultimate aim of the MAP is for staffing in Mental Health Services in Malta to reach parity with physical health services. The MAP is aware that in physical health services in Malta the number of specialised physicians available per capita are at par with the average number of physicians per capita reported for the EU.

## Introduction

One in four people in the world will be affected by mental or neurological disorders at some point in their lives, around 7% of the population are users of mental health services (WHO 2001). Around 1 in 6 adults have a common mental disorder, whilst 1 to 2% of adults suffer from an enduring mental disorder and 1 in 20 adults have a personality disorder. Around 1 in 5 mothers develop mental disorders during pregnancy or within the first year postpartum, whilst 1 in 14 adults over 65 and 1 in 6 adults over 80 will develop dementia. The **economic impact of poor mental health** is estimated to be over £100 billion to the economy each year in England alone (Bhugra 2012). The UK spends more on mental health services than on any other area of health (Bhugra 2012).

The Royal Australian and New Zealand College of Psychiatrists recommend that there should be 1 psychiatrist per 7,500- 10,000 population (Burvill, 1992). The Royal College of Psychiatrists in the UK recommend 1 child and adolescent psychiatrist per 50,000 population (RCP, UK 2013).

Based on these recommendations, Malta requires between 45 to 60 psychiatrists working in general adult mental health and 9 psychiatrists working with children and adolescents.

At the time of writing, in mental health services, there are no full-time child and adolescent psychiatrists in Malta, and there are 15 consultant general psychiatrists and 10 qualified resident specialists (RS) in Malta's NHS.

It is important to note that there are also no specialised Community Services. We have no home treatment provision, early intervention services or services working directly with Education services. Similarly, we lack specialised teams working with child and adolescent or forensic populations. We also do not have services dealing with personality disorders. This means that there is no opportunity for professionals and teams to develop an expertise in working with specific groups of individuals or individuals with specific needs.

In May 2018, the Maltese Association of Psychiatry (MAP) met up with the Minister of Health Hon Fearne and were tasked with the exercise to benchmark the local mental health service against international standards and reported practices. This report focuses on General Adult Services and Child and Adolescent Services. Sub-specialities (for example forensic, old age psychiatry) will be reported on separately.

The key sources of information for this work are drawn from data published by the World Health Organisation and the Royal College of Psychiatrists, UK. Unfortunately, there is very little reliable good quality local data and no local epidemiological data on mental disorders. Despite these limitations, the MCH management collaborated with MAP and provided sufficient raw data for MAP to start to develop an early understanding of mental health services to allow some meaningful comparisons with international data and draw up some broad conclusions.

Throughout this document, the terms outpatient clinic is intentionally used for specialist-patient contacts that occur outside of hospital wards and to avoid any confusion with what would be recognised as a community mental health service or team in a developed country. The MAP is aware that there are clinics in different regions in Malta that are called Community Mental Health Teams, or services; however, these services are grossly understaffed and therefore do not provide the same service as what is understood internationally as a community mental health team or service in a developed country.

## General Adult Psychiatry Services

### A. Numbers of Psychiatrists

Figure 1 displays Malta's number of psychiatrists per million population, as reported by the WHO in 2015; of note the number quoted includes all doctors working in psychiatry as is requested by the Eurostat questionnaire. Malta is at the bottom of the table of EU countries in terms of numbers of "psychiatrists" (per inhabitants).

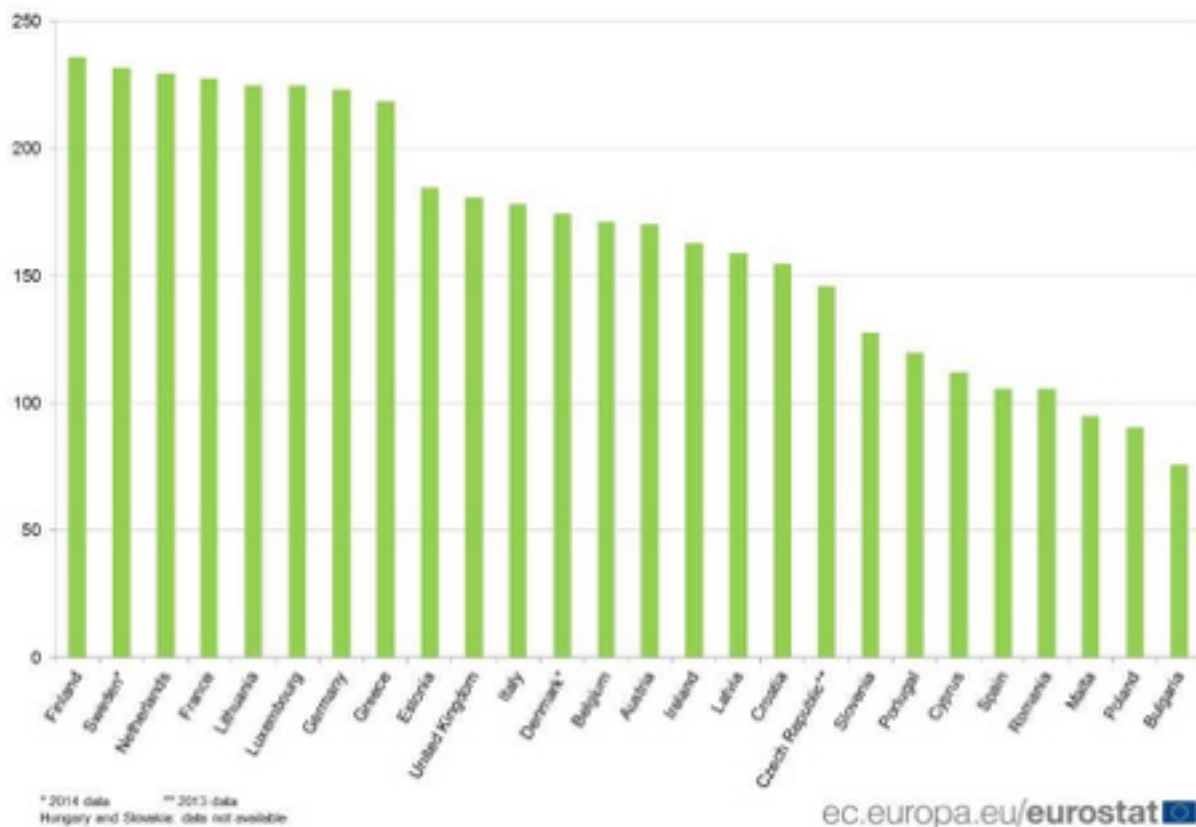


Figure 1. Number of psychiatrists per million inhabitants in the EU Member States 2015 (World Health Organization, 2015)

## B. Numbers of patients seen by psychiatrists.

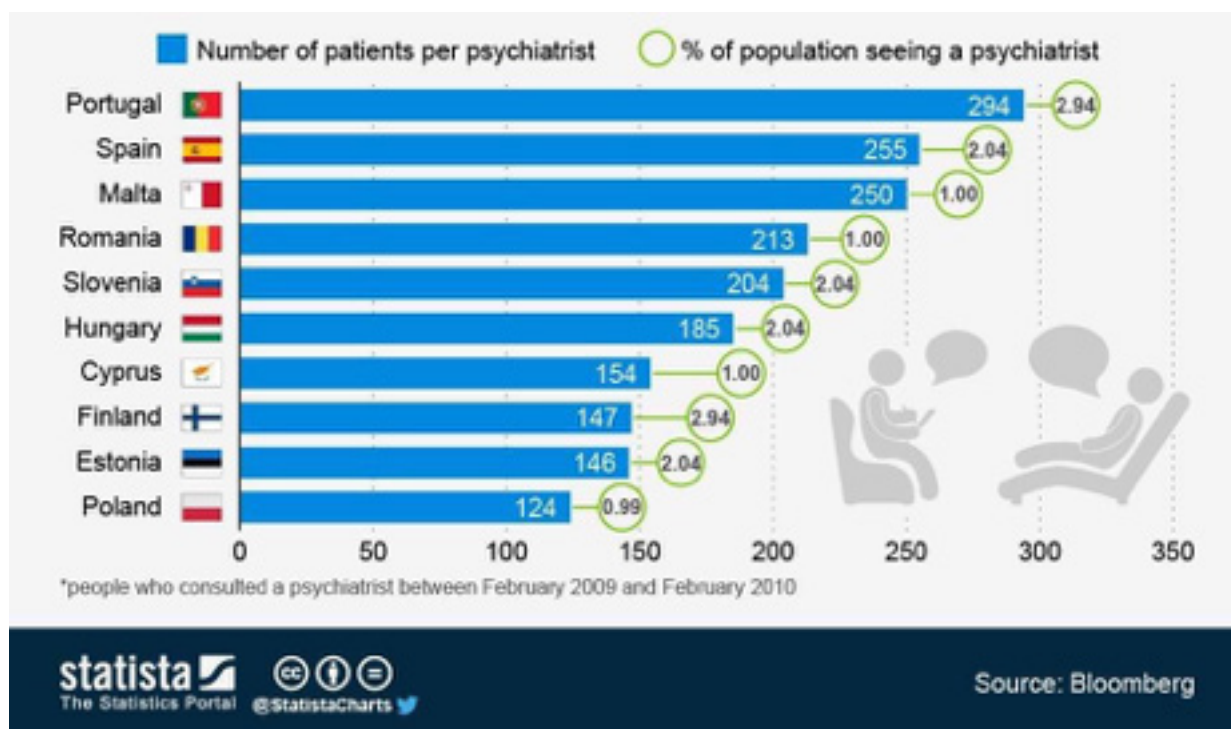


Figure 2 Number of patients per psychiatrist (McCarthy, 2013). Psychiatrists in Malta reviewed a mean number of 250 patients per year in 2009- 2010.

Data provided to us shows that in 2017, 9873 individuals were seen by the mental health services and just over half (5246) were seen in out-patient clinics, the rest being seen by CMHTs. This equated to 18,668 outpatient contacts of which 1,426 were new patient contacts. Therefore, given the number of psychiatrists employed by the mental health services and assuming an equitable workload, each consultant/psychiatrist saw around 750 patients. This differs significantly from the data for 2009-2010 reported in figure 2. Furthermore, it is important to keep in mind that each consultant and resident specialist works an average of 0.2 working time equivalent in community mental health, therefore a full time equivalent would have reviewed around 3,750 patients. It is of note that it is likely that these figures are significant underestimates as there are no electronic notes to accurately collate number of patient contacts.

This appears to us to be an excessive number of patients per consultant and we believe impacts on our ability to provide a good quality of care to patients and is likely to result in significant burnout. Developing adequately resourced community services and encouraging continued specialised professional development of other professionals for example clinical psychologists, specialist nurses and GPs with an interest in psychiatry as part of a national mental health strategy will result in more effective treatment and interventions and a better quality of care for patients, allowing psychiatrists to focus on patient assessment and the management of the more complex mental health conditions.

It should be noted however that we have significant reservations about the quality of the collected data, partly because in Malta we do not have electronic case notes system, where each and every patient contact is recorded, and the service evaluated and audited. Therefore, the MAP speculates that this figure is an underestimation of the yearly number of reviews carried out per psychiatrist on our island.

The Royal College of Psychiatrists has a long track record of developing and evaluating standards of care in psychiatry. The Royal College of Psychiatrists (RCPsych) College Report CR207 (CR207, 2018) states: “Consultants working in well-resourced mental health teams will be able to focus on patients with more severe and complex disorders, whereas if there is limited availability of other professional skills, the psychiatrist will provide direct care to a broader patient cohort”.

System structures in primary care medicine in Malta, limit effective continuity of care. As a result, communication between the psychiatrist and the primary care physicians, and the transition of service users from secondary services to primary services is hindered. Consequently, the psychiatrist continues to see service users unnecessarily for many years because of a lack of primary care psychiatric provision. The lack of developed community services utilizing the skills of other professionals and specialists further compounds the difficulty,

The CR207 (RCPsych, 2017) report also recommends that the clinical roles for community based general adult psychiatrists and in-patient general adult psychiatrists should be defined and specific for both. It is clearly recognized also that there is a role for some psychiatrists, especially those with specialty services to have both in-patient and out-patient input. Notably, consultants also have leadership, educational and academic roles.

As such, the RCPsych suggests that general adult psychiatrists have **either an in-patient or an out-patient role**. Services across the UK have adopted a “functionalised” model of care, which involves splitting community and in-patient care. This offers some benefits, most notably in the in-patient setting with fewer consultants being responsible for patient care on busy in-patient units. However, for the patient this introduces a significant interface in their care pathway. This interface has the potential of creating a significant discontinuity in the care provided to patients and appropriate planning to manage this interface needs to be explicitly designed and specified in job descriptions if an in-patient/out-patient split is to be considered. It is of note that some services in the UK are reverting to a model of care where continuity of care can be provided for service users with MDT providing a range of specialist roles including in-patient care, home based treatment and assertive outreach for example.

In Malta, historically, we have followed a service delivery model that emphasizes Continuity of Care. Under this model, consultant psychiatrists are responsible for the totality of psychiatric care for patients in their caseload including their general physical care as well as psychological and other not physical interventions. Some aspects of a functional model of care has gradually developed in Malta and in 2017 two specialists were appointed to work full time on the in-patient service. Since then and very recently, three consultants have been tasked with only acute adult in-patient care, while the rest continue to work both in-patient and out-patient services as well as running a specialty service. Out-patient clinics are not located close to in-patient beds and therefore it may be difficult to provide day to day cover across both in-patient and out-patient services. For psychiatrists working in both in-patient and out-patient services the RCPsych recommend a 2:3 in-patient: outpatient split.

In keeping with the shift from in-patient to community care, the RCPsych recommends that services need to be established and designed to provide intensive support to patients as an alternative to hospital admission. Such services need to be consultant led and multi-disciplinary. One model suggested is the development of Crisis and Home treatment teams. No such services exist in Malta. These must be staffed by consultants and senior trainees (HST only). Unfortunately, in Malta the only service in existence is a day-time service operating from Mater Dei and staffed by trainees without the support of a multi-disciplinary team and no continuity of care.

Safe and effective delivery of clinical services is underpinned by a **good administrative system**. This includes having admin support to release clinical staff from administrative tasks and facilitate communication and liaison as well as an effective electronic records system both of which are lacking in Malta.

## Comparison to International Standards

	Malta Current	Recommended	Standard
<b>Psychiatrists working in Mental Health Service</b>	11 adult consultants 15 total consultants 26 psychiatrists  (5/100,000)	50  (Norway: 30/100,000 UK: 14/100,000)	Burvill, 1992  WHO Report
<b>Nurses</b>	67/100,000	UK: 67/100,000 Norway: 123/100,000	WHO report
<b>Psychologists</b>	4/100,000	UK: 13/100,000 Norway: 54/100,000	WHO Report
<b>Social workers</b>	5/100,000	UK: 2/100,000 Norway: 26/100,000	WHO Report

## Community Psychiatric Services – Specialist needs for Malta

	Malta Current	Recommended	Standard
<b>CMHT</b>	5 teams (0 FT psychiatrists, but consultant clinics which take place between once a week to once every 6 weeks)	12.5 consultant psychiatrists	WHO/ RCPsych 1/30,000-40,000
<b>Assertive Community treatment</b>	0	5 FT psychiatrists	1/100,000
<b>Early Intervention in Psychosis</b>	0	2 FT psychiatrists	1/250,000
<b>Home Treatment Teams</b>	0	3 FT psychiatrists	1/150,000

To meet the WHO/RCPsych standards for number of consultant psychiatrists, Malta requires at least 22 Full Time equivalent consultant psychiatrists working in the community. There are currently 3.5 FTE consultants, and these are supported by only a few other allied health professionals. As a result of the limited number of consultant psychiatrists working in the community and the lack of multidisciplinary support, these teams often follow a biological model of care and cannot provide a holistic psychiatric service – for example they can only provide a very limited number of home visits.

The service provided to service users within the community does not follow the recommended guidelines for reviews (frequently recommended every 2-4 weeks).

On consultation with colleagues in the UK, MAP was informed that consultant psychiatrists working in the community out-patients would see a total of 4-5 patients a day, followed by having time for reflection, MDT meetings and administrative and managerial time. All this adds up to approximately 20 patients per week. In 2017, the local community services had 18,668 (12,171 at POP and 6,497 at CMHT) recorded patient contacts with psychiatrists. and 3,750 patient contacts per year. The numbers reviewed by the Maltese psychiatrists are more than 4.5 times higher than the number of patient contacts recommended by the RCPsych RC207 document.

### In-Patient Psychiatric Services - Specialist Needs for Malta

	Malta Current	Recommended	Standard
<b>Consultant attendance on in-patient unit</b>	1-2 times a week	daily	RCPsych
<b>MHA Formal pt review by consultant</b>	weekly at best	3 times a week	RCPsych
<b>MHA Informal pt Review by consultant</b>	weekly at best	weekly at least	RCPsych
<b>Number of consultants</b>	4 FTE	7	RCPsych: 1 consultant for 15 patients

## Child and Adolescent In-Patient and Community Report

*“It is a paradox that, in the second half of the 20th century, indicators of social wealth and physical health amongst children worldwide have improved, while mental health indices in young people are deteriorating” (Rutter 1995)*

Mental disorders are a major cause of ill health, in young people (YP) (WHO, 2009). Of those aged up to 18 years one in ten have a mental disorder but only half access services and only a fifth specialist child and adolescents mental health services (CAMHS) (Ford, Goodman, & Meltezer, 1999). The burden of disease increases by 2.5 times between the ages of 10 to 14 years and 19 to 24 years (Gore et al., 2011). The main identified causes for this are neuropsychiatric disorders, these include (most prevalent listed first); unipolar depression, schizophrenia and bipolar disorder (Gore et al., 2011). Of adult mental disorders, 75% emerge before the age of 25 years (Royal College of Paediatrics and Child Health, 2003). These ‘chronic diseases of the young’ have high rates of long term morbidity and mortality (McGorry, 2009). Hence, timely and successful access to mental health services in adolescence and early adulthood is a public health priority (Davies, 2013; NICE 2016).

Older adolescents and young adults negotiate multiple transitions in most aspects of their life such as further education or employment, moving out of home, forming relationships and becoming independent. In the presence of other psychosocial stressors vulnerable young adults can fail to make these transitions effectively, which may result in a range of adverse consequences impacting on their mental health (Reder, McClure, & Jolly, 2000; Social Exclusion Unit, 2004). These include homelessness, lack of training or education, poor health (Social Exclusion Unit, 2004), anti-social behaviour, substance misuse (Fonagy, Target, Cottrell, Phillips, 2000) and crime (Social Exclusion Unit, 2004). However, mental health service provision for older adolescents and young adults is often inconsistent and not adequately supportive during this period (Department of Health, 2002). At least until recently fewer than 25 % of mental health services had documented evidence of specific transition arrangements from CAMHS to adult mental health services (AMHS) (Singh, 2009). Indeed, 30 to 60% of YP attending CAMHS services may be ‘lost to follow up’ when transitioning to AMHS (Singh, 2009). Therefore, consideration of facilitators and barriers is important when considering service development for YP (Hendry & Polson, 2007; Watson, Parr, Joyce, May, & Le Couteur, 2011).

## Recommended staff numbers for a CYPS Outpatient Service

Staff numbers for Malta in comparison with other CAMHS services in Europe are documented in Table 2 below. In 2017 there were the equivalent of 1.4 full time equivalent (FTE) psychiatrists working in CAMHS (0.8 FTE Child and adolescent psychiatrists and 0.6 FTE Resident Specialists). A Vision for Change (RCPsych 2006) recommends that there should be at least two Child and Adolescent Community Mental Health teams per 100,000 population, (see Table 2). If the vision for change document and the Royal College of Psychiatrist UK recommendations are followed, there should be 1 Children and Young People Service (CYPS) provided on the Maltese Islands per 50,000 of the population and 1 Child Liaison service per 300,000 of the population. To date in Malta the latter is covered by 1 FTE Adult Liaison psychiatrist.

	Malta	Newcastle/ Gateshead	Ireland	Recommended for Malta
Population	450,000	500,000	4.8 million	
CAMHS Consultant	0.8	5	68.2	9
Psychotherapists	0	2	0	3
Resident Specialist	0.6	3	13.2	0
Nurse Consultant	0	0	0	3
Nurses	4	39	105.4	18
Consultant Psychologist	0	1	0	2
Warranted Psychologists	2	13	68.8	18
Psychology assistants	2.6	2	0	0
Social workers	1.5	1	78.5	18
Occupational Therapists	1	8	50.9	9
Support worker	0	7	39.5	9
Speech Therapist	0	0	50.6	9
Administrative staff	3	9	n/a	18

Table 2 Comparison of staffing between Malta, Newcastle/Gateshead and Ireland

## **Caseload for Doctors as recommended by the Royal College of Psychiatrists job description document CR207**

An indicative case-load as recommended by the Royal College of Psychiatrists would be:

- 1–2 new/initial assessments a week
- 10–17 follow-up case slots a week.

A psychiatrist working full time in Malta at present reviews a mean of 2.8 new cases per week and 27 follow ups per week. Both figures are higher than the recommended numbers published by the RCPsych (Adamou, 2017).

The CYPS annual report for Malta documented that there were 361 new cases referred to CYPS in 2017. This number is very low when compared to Newcastle Tyne and Wear Foundation Trust, UK who receive 270 referrals per month. Reasons for those could be many, however the MAP anticipates a significant increase in number once the stigma on mental health decreases and the reputation of the service improves once the number and high quality interventions for children and young people improves.

In 2017 the mean waiting time from time of referral to initial appointment was 187.6 days ( $CI \pm 26.9$ , 0-720), and 301.0 days ( $CI \pm 34.4$ , 0-800) for the first specialist review (Saliba and Camilleri 2017). This waiting time is considered to be significantly longer than the mean waiting time in CAMHS - UK which is an average of 21 days. Furthermore, the total contacts for CAMHS UK services are around 12,962 contacts per 100,000 population in the 0-18 age groups of which 82% are taken on for intervention. The rest are referred back to primary care or referred on to an alternative, more appropriate service. This number of follow ups reviewed by CAMHS, UK is significantly higher than the 3922 patient contacts in CYPS Malta for 2017. This may be explained by the grossly understaffed CYPS service in Malta, stigma and lack of awareness around mental health and or parents choosing the independent over the public sector.

The average service user on the CAMHS -UK Tier 1-3 caseload receives 6 interventions per annum with young people remaining in service for around 12 months. There is no data on the rates of missed appointments in Malta and in the UK the rates vary significantly with some services having a rate of 2% while others have a rate of 25% (average of 11%).

	Number of patients per year	Recommendations for staff 1 WTE	Malta staff per 1 WTE
New Cases	361	1-2/week	2.8/week
Psychiatric follow ups	3451		
ADHD school visits	89		
Autism school visits	11		
ADI	31		
ADOS	30		
DBT groups	52		
Incredible years	181		
Cygnnet groups	77		
Total Reviews	3922	10-17/week	27/week

Table 3 Number of new cases and follow ups for Children and Young People's Services in Malta.

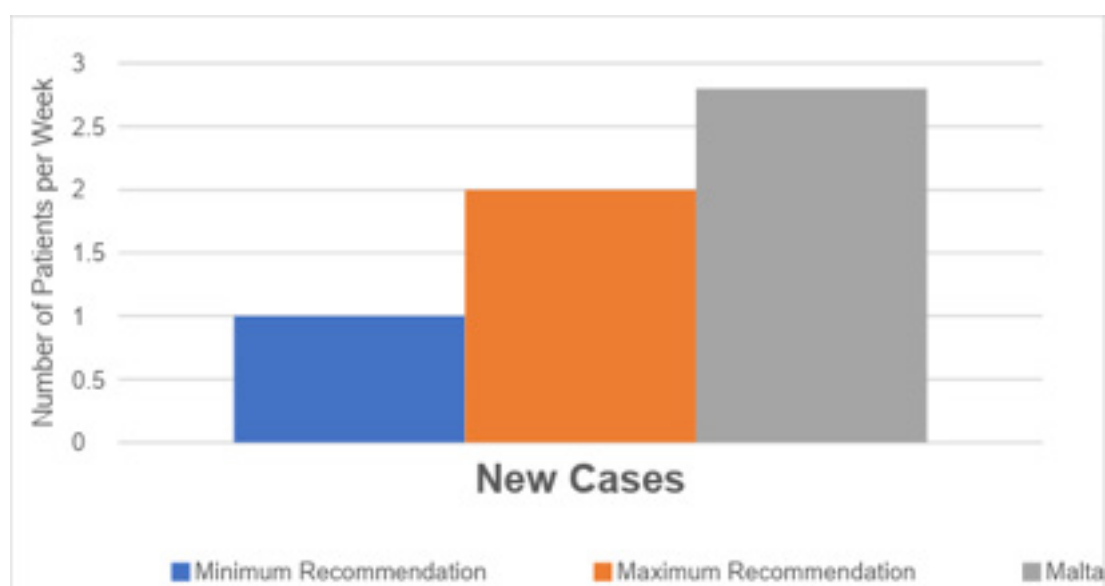
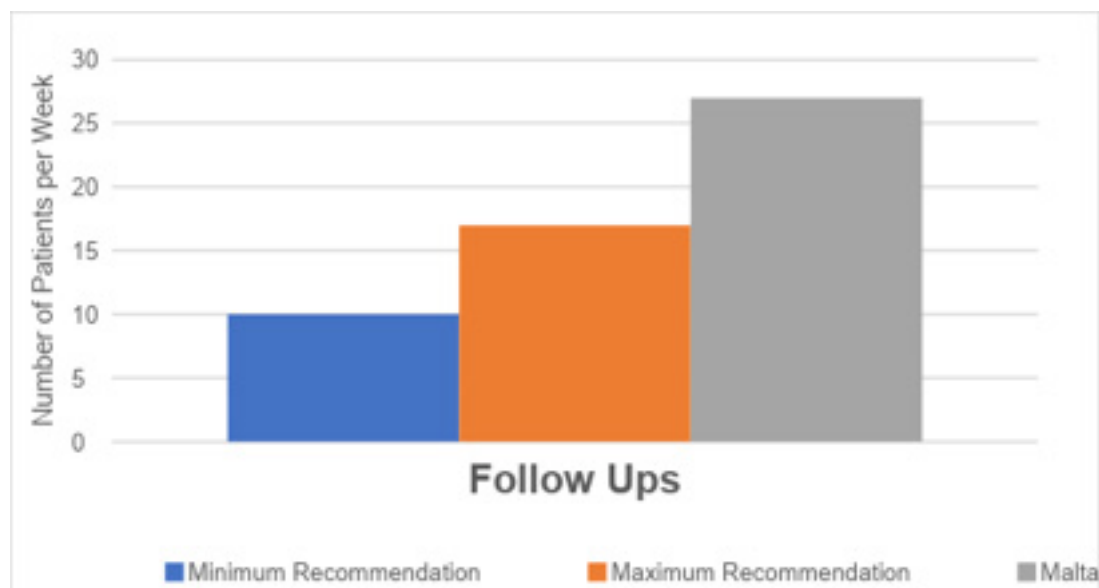


Figure 3 Comparison of Maltese new cases to recommendations

infomapsych@gmail.com



*Figure 4 Comparison of Maltese follow ups to recommendations*

## CYPS In-patient Service

In the UK, in-patient services and highly specialist services for children and young persons and are referred to as Tier 4 services. They typically cover sub-regional footprints and are commissioned by specialist commissioners.

The Royal College of Psychiatrists estimates that “24 – 40 in-patient CAMHS beds are available per 1 million total population to provide mental health services for children and adolescents from 12 years up to age 18 with severe mental health problems that require emergency or very intensive treatments” (RCPsych 2013). children under the age of 12 with mental health problems who require in-patient care are admitted to the paediatric wards.

The recommendations are that a consultant psychiatrist’s job plan should allow for daily ward visits, at least a weekly face-to-face review of each patient, team meetings, complex case review meetings and sufficient time for liaison with families and other agencies. In Manchester each Full-time equivalent consultant is responsible for between 5-8 beds. It is also important to ensure that there is adequate cover for consultant absence and leave.

At present Malta has a 14 bedded inpatient unit covered by 0.6 FTE consultants. Royal College recommendations suggest a need of at least 1.3 FTE consultant psychiatrists. As with adult mental health services, Malta has a larger number of beds per capita than other developed countries. This is likely to be due to the lack of alternative appropriate community mental health services and other services that compliment these including home treatment provision and secure residential care homes for young people with challenging behaviours.

Bed occupancy rates are generally high for CAMHS tier 4 inpatient services at 88% with an occupancy rate of 72% if patients on rehabilitation leave home are excluded. The average length of stay for 2013 was 58 days excluding leave and 68 days when leave is included. The length of stay for children in secure CAMHS services was 115 days.

Analysis of the tier 4 UK CAMHS workforce shows that it is medically led but with significant support from other professions especially from a nursing background. Medical staff are 6.7% of the tier 4 workforce, whilst nurses and support workers account for 73%. Specialist therapists are less evident in the CAMHS services with just 4% of staff being from a Clinical Psychology and Psychotherapy background.

Tier 4 in-patient unit	
Description	Professional activities (PAs) per week
Direct clinical care	7.5
Ward-based clinical activity including clinical decision meeting, interviewing patients and carers	4.5
Liaison with families and other agencies	2.5
Clinical administrative tasks	0.5
Supporting professional activities (CPD, QI activity, supervision, appraisal and job planning)	2.5

Table 4 Job plan for UK consultant child and adolescent psychiatrists working with in-patients.

	Malta	NTW	TEWV	Ireland
<b>Beds</b>	14	12	8	74
<b>Population</b>	500,000	1.4 million	1.6 million	4.8 million
<b>Consultant Psychiatrist</b>	0.6	1	1.8	6.4
<b>Consultant Psychologist</b>	0	1.5	0	0
<b>Consultant Nurse</b>	0	0.8	0.8	0
<b>Resident Specialist</b>	0	0.8	0	2.5
<b>Trainees</b>	0.8	1	2	9.5
<b>Foundation Doctors</b>	0.6	0	0	0
<b>Nurse Manager</b>	1	2	2	18.5
<b>Nurses</b>	11	16	11.6	88
<b>Warranted Psychologists</b>	0.25	2	1	6.61
<b>Psychology assistants</b>	1.5	3	1	
<b>Social workers</b>	1.5	1	0	6.3
<b>Occupational Therapists</b>	0.5	3	0	4.3
<b>SLP</b>	0	0	0	2.3
<b>Teaching staff</b>	2	3	0	14.9
<b>Nursing aides</b>	2		15.8	11
<b>Clerk</b>	1	2		6.5
<b>Dietician</b>	0	0	0.5	1.7
<b>Pharmacist</b>	0	0.2	0.5	0

*Table 5 Comparison of staffing between Malta, Northumberland, Tyne and Wear NHS Foundation Trust (NTW), Tees, Esk and Wear Valleys Foundation NHS Trust (TEWV) and Ireland*

## References

- Adamou, M., Agarwal, P., Barber, R., Bodani, M., Bolton, J., & Brown, M. (2017). *Safe patients and high-quality services job descriptions for consultant psychiatrists*. ( No. CR207). London: Royal College of Psychiatrists. doi:November 2017.
- Burvill, P. (1992). *Looking beyond the 1: 10,000 ratio of psychiatrists to population*. Australian & New Zealand Journal of Psychiatry, 26(2), 265-269.
- Camilleri N., Newbury Birch D., McArdle P., Stocken D., LeCouteur A. *A case control and follow study of 'Hard to Reach' Young People who also suffered from multiple complex mental disorders*. Child and Adolescent Mental Health journal 01/02/17 pg 49-5
- CR207 (2018). Royal College of Psychiatrists: Safe patients and high-quality services. Job descriptions for consultant psychiatrists. Available online: [https://www.rcpsych.ac.uk/files/pdfversion/CR207\\_v2.pdf](https://www.rcpsych.ac.uk/files/pdfversion/CR207_v2.pdf)
- Davies, D. S. C. (2013). *Annual Report of the Chief Medical Officer*. Retrieved from Department of Health, UK: [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/351629/Annual\\_report\\_2013\\_1.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/351629/Annual_report_2013_1.pdf)
- Fonagy, P., Target, M., Cottrell, D., Phillips, J. (2000). A review of the outcomes of all treatments of psychiatric disorder in childhood. *MCH 17- 33- final report to the NHS Executive*. Retrieved from <http://www.doh.gov.uk/research/mch/studies/execsum17-33.htm>
- Ford, T., Goodman, R., & Meltzer, H. (1999). The British Child and Adolescent Mental Health Survey 1999: The Prevalence of DSM-IV Disorders. *Journal of the American Academy of Child & Adolescent Psychiatry*, 42(10), 1203 - 1211.
- Gore, F.M., Bloem, P., Patton, G.C., Ferguson, J., Joseph, V., Coffey, C., . . . Mathers, C.M. (2011). Global burden of disease in young people aged 10–24 years: a systematic analysis. *The Lancet*, 377, (9783), 2093-2102.
- McCarthy, N. (2013). Portugal has the EU's busiest psychiatrists. Retrieved from <https://www.statista.com/chart/1679/portugal-has-the-eus-busiest-psychiatrists/>
- Mental Health Division. (2017). *HSE mental health division delivering specialist mental health services 2016.. Ireland*
- Reder, O., McClure, M., & Jolly, A. (2000). Interface between child and adult mental health. In *Family Matters: Interface between child and adult mental health*, London. Routhledge., 3-20.

Saliba A, Aguis D, Sciberras E, Camilleri N. A population service evaluation of the Attention Deficit Hyperactivity Disorder pathway of Children and Young People's Service, Malta Chronicles of Pharmaceutical Sciences. Vol2 Issue 1 2018 pg. 453-461

Singh, S. P. (2009). Transition of care from child to adult mental health services: the great divide. *Current Opinion in Psychiatry*, 22(4), 386-390.

Social Exclusion Unit. (2004). Breaking the Cycle. In Office of the Deputy Prime Minister (Ed.). London.

Social Exclusion Unit. (2005). Transitions: Young Adults with complex needs- A Social Exclusion Unit final report. *Office of the Deputy Prime Minister 2005*.

Watson, R., Parr, J. R., Joyce, C., May, C., & Le Couteur, A. (2011). Models of transitional care for young people with complex health needs: a scoping review. *Child: care, health and development*, 1365-2214

World Health Organization. (2015). *World health statistics 2015* World Health Organization.

WHO. (2009). *Global Health Risks, Mortality and burden of disease attributable to selected major risks*. Retrieved from WHO, Geneva, Switzerland:

World Health Organization. (2016). Global health observatory (GHO) data. 2016. *Child Mortality and Causes of Death*. WHO, Geneva.