Youth Mental Health in Malta

DR JOHN M CACHIA MD MSc FFPH MMCFD
Commissioner for Mental Health, Malta

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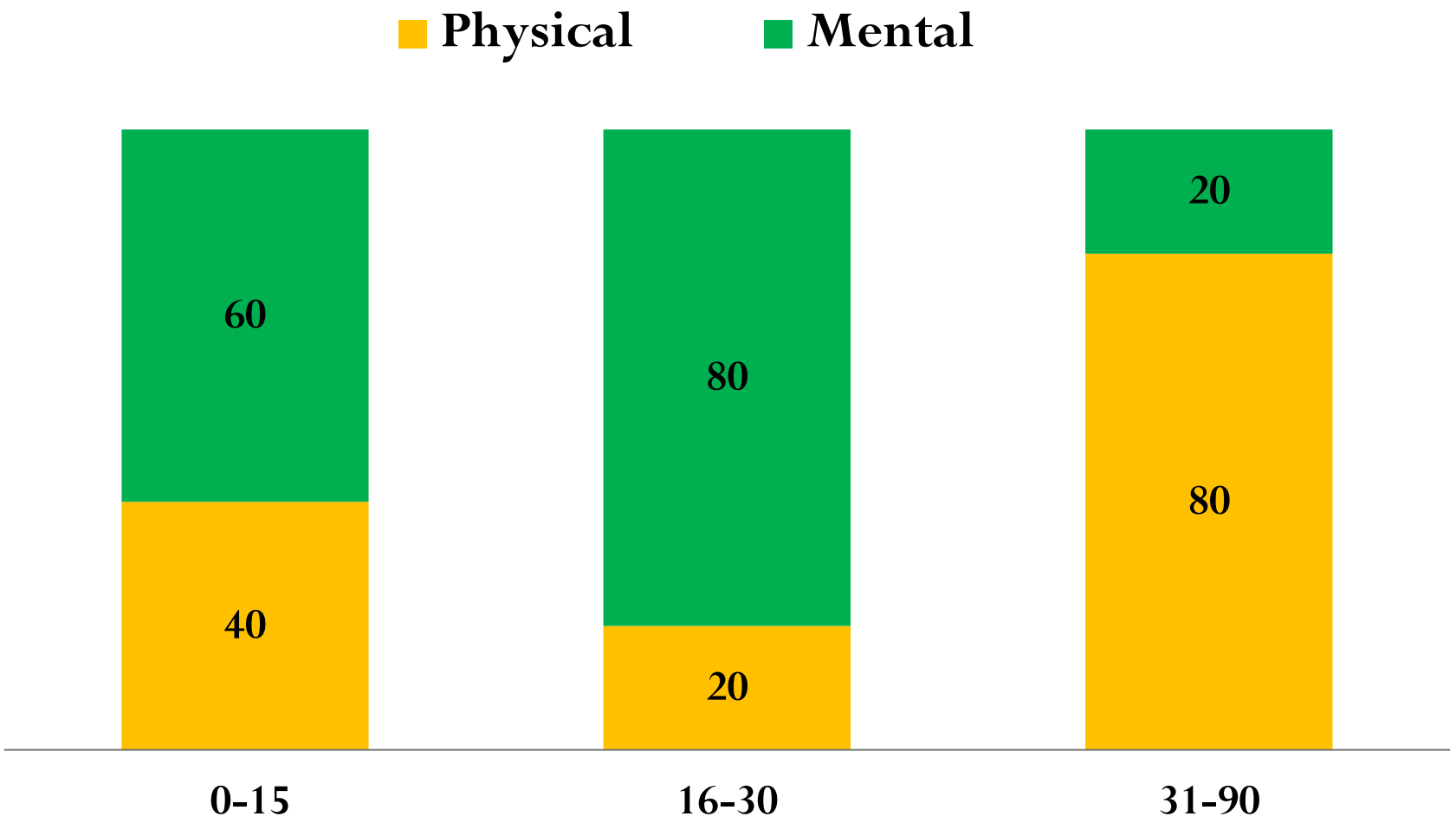
The Facts

- Mental disorder is the major public health challenge in adolescents and young adults.
- 1 in 5 teens and young adults live with a mental health condition.
- Half of all lifetime cases of diagnosable mental illness begin by age 14 and three-quarters of lifetime mental illness arise by mid-twenties. However,
- 60–70% of children and adolescents with clinically significant mental health problems have not been offered evidence-based interventions at the earliest opportunity for maximal lifetime benefits.
- Unlike other health problems such as cancers and heart disease, most mental illness begins early and may persist over a lifetime, causing disability when those affected would normally be at their most productive.
- These statements justify a stronger focus on the mental health of persons aged less than 30 years.

Lifetime Burden of Chronic Disease



WHO, CAMH Policies & Plans

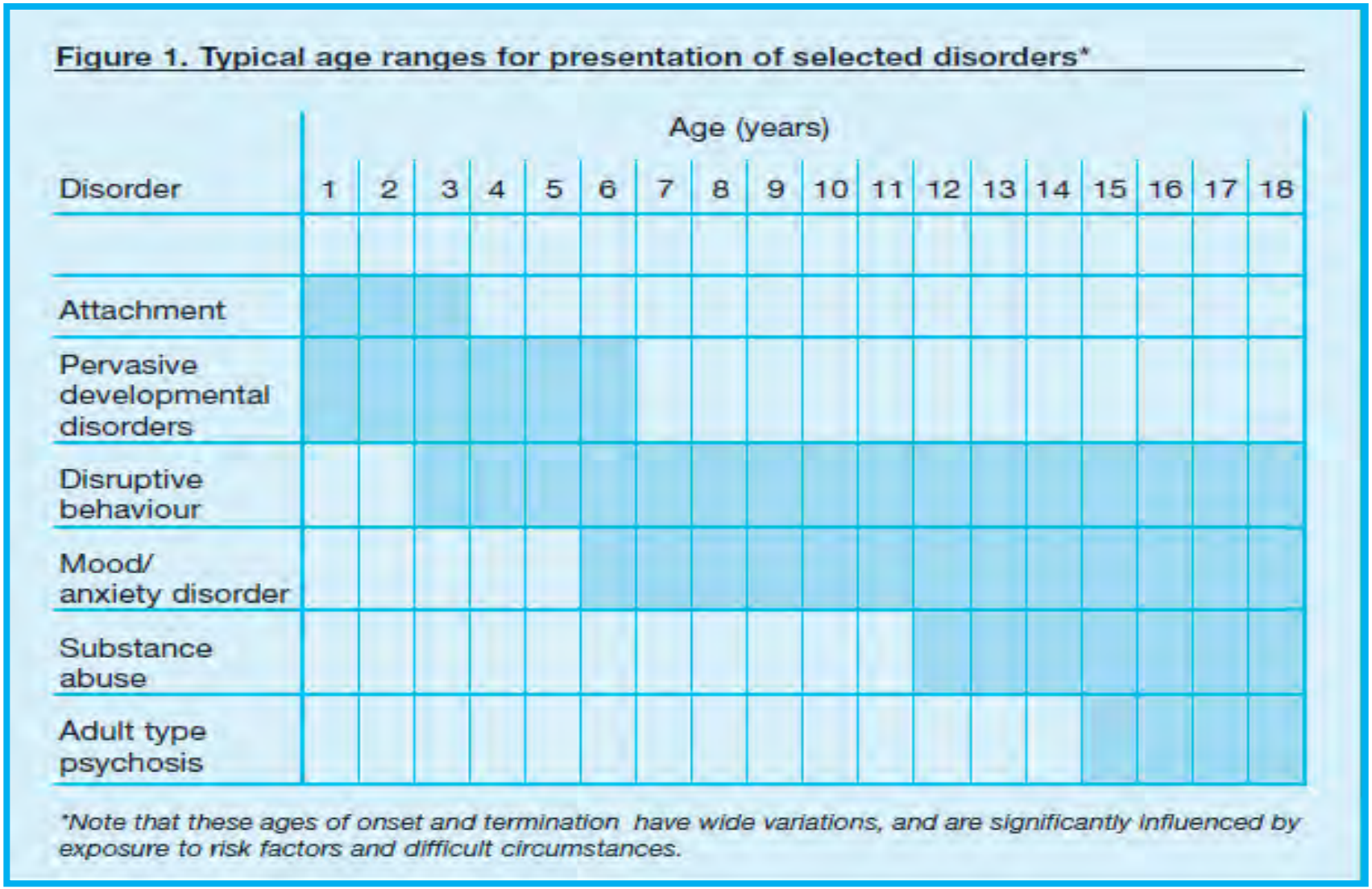


Figure 1. Typical age ranges for presentation of selected disorders*

Disorder	Age (years) 1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
Attachment																		
Pervasive developmental disorders																		
Disruptive behaviour																		
Mood/ anxiety disorder																		
Substance abuse																		
Adult type psychosis																		

**Note that these ages of onset and termination have wide variations, and are significantly influenced by exposure to risk factors and difficult circumstances.*

Methodology

- Persons aged 30 years of age or less with acute mental disorder who were admitted involuntarily for observation between 1st January 2015 and 31st December 2015
- Based on notifications of Involuntary Admission for Observation received at the Office of the Commissioner for Mental Health in accordance with the requirements of Schedule 2 of the Mental Health Act
- A person may only be admitted involuntarily if a specialist in psychiatry certifies that such person (a) has a severe mental disorder, and (b) there is a serious risk of physical harm to that person or to other persons, and (c) failure to admit or detain that person is likely to lead to a serious deterioration in his/her condition or will prevent the administration of appropriate treatment that cannot be given in the community
- Involuntary Admission for Observation has a maximum duration of ten (10) days. Acute treatment and care is administered with the scope of control and stabilisation of the acute condition leading to discharge or switching to voluntary care.

Notifications received

- A total of 426 valid notifications of Involuntary Admission for Observation
- 117 notifications (**28% of all acute admissions**) from 95 persons
- **Re-admission risk of 21%** within 3 months first admission. Of these 20 persons with at least one re-admission, 11 were Maltese citizens, 6 were asylum seekers, 2 were Eastern European non-EU citizens and 1 was a non-Maltese EU citizen.

Type	No. of Persons	No. of Admissions
1 Admission	75 persons	75 admissions
1 Admission + 1 Re-admission*	18 persons	36 admissions
1 Admission + 2 Re-admissions*	2 persons	6 admissions
Total	95 persons	117 admissions

*defined as re-admission within 3 months from first date of admission

Age and Gender

- Gender distribution was 61% males to 39% females.
- The overall age distribution was: 12.6% were less than 18 years of age, 20.0% were aged 18 to 20 years, 28.4% were aged 21 to 25 years and 38.9% were aged 26 to 30 years.
- **1 admission per 1000 youths from 18 years onwards**

Age Group	Male	Female	Total	Rate/1000 pop
<13 years	2	0	2	n.a.
13-17 years	3	7	10	0.430 (10/23256)
18-20 years	10	9	19	1.177 (19/16147)
21-25 years	18	9	27	0.877 (27/30786)
26-30 years	25	12	37	1.199 (37/30864)
Total	58	37	95	

Age and Gender stratification

Age Group	Male	Female	Total
13-17 years	0.252 (3/11905)	0.617 (7/11351)	1 Male = 2.5 Female
18-20 years	1.185 (10/8441)	1.168 (9/7706)	1 Male = 1 Female
21-25 years	1.132 (18/15898)	0.605 (9/14888)	2 Male = 1 Female
26-30 years	1.544 (25/16190)	0.818 (12/14674)	2 Male = 1 Female
Total	1.068 (56/52434)	0.761 (37/48619)	3 Male = 2 Female

Admissions by Residence

Residence	Persons	Percentage	
Address in Malta	44	47.3%	
Address in Gozo	6	6.5%	**59.2%**
Care Home residents (Maltese/Gozitan)	5	5.4%	
Correctional Facility (all foreigners)	5	5.4%	
Seeking refuge or asylum	19	**20.4%**	
Other EU or EEA (non-Maltese)	11	11.8%	
Eastern European	3	3.2%	
Total	93	100%	

By Address on Notification

Residence	Persons	Rates/1000 population 13-30 years
Address in Malta	44	0.535 (46/86036)
Southern Harbour	*10*	0.575 (10/17384)
Northern Harbour	*11*	0.429 (11/25625)
South Eastern	*5*	0.338 (5/14814)
Western	*8*	0.577 (8/13872)
Northern	*10*	**0.697 (10/14341)**
Address in Gozo	6	**0.810 (6/7404)**
Care Home residents	5	
Corradino Correctional Facility	5	
Seeking refuge or asylum	19	**9.009 (19/~2100)**
North Africa/Middle East	*5*	
East Africa	*8*	
West Africa	*6*	
Other EU or EEA (non-Maltese)	11	
Eastern European	3	

Diagnostic category

Disease Category	Male	Female
Organic mental disorders	1.8%	nil
Mental and behavioural disorders due to psychoactive substance use	8.8%	5.4%
Schizophrenia, schizotypal and delusional disorders	**50.9%**	**29.7%**
Mood [affective] disorders	**15.8%**	**35.1%**
Neurotic, stress-related and somatoform disorders	1.8%	nil
Disorders of adult personality and behaviour	1.8%	2.7%
Intellectual disability	8.8%	13.5%
Disorders of psychological development	1.8%	nil
Behavioural and emotional disorders with onset usually occurring in childhood and adolescence	8.8%	13.5%

Longer Involuntary Care

- From among these 95 persons, there were 26 youths (27%) who required at least one additional period of involuntary care lasting up to a further ten (10) weeks
- Re-admission was a highly significant predictor of longer involuntary acute care needs (**The chi-square statistic is 9.7304. The p-value is .001812. This result is significant at $p < .01$)*

	Number of admissions	Proceeded to longer involuntary care (IATO)	Switched to voluntary / Discharged
Single Admission	75	15	60
> one admission	20	11	9
	95	26	69

Considerations

- The above data focuses only on the most severe form of mental disorder in youth in Malta.
- The evidence from the United States and the UK shows that the youth at risk within our families, schools, clubs and communities are many more.
- Most adolescents and young adults can live full lives with a mental health condition.
- In order to function properly in the long term, mental health services for children, adolescents and young adults require holistic horizontal approaches involving mainly health, education, and welfare.
- It does not make epidemiological sense to transition Children and Adolescents to Adult Psychiatry on their 18th Birthday!!!

Conclusions – person centred care

- Better mental health for our youth is an investment in the future of our society
- A balanced care approach with primary care-givers involved in early detection and intervention
- Adequate referral pathways to specialised services
- Access and rapidity of response are critical. Waiting times must be as short as possible.
- Services must reflect caring needs with step-up and step-down possibilities aimed at short, sharp focused interventions and rapid return to the normal life.
- Care models to include life-skills building and work-training approaches in order to improve coping mechanisms.

The person requiring care must be at the centre of care and all significant others who can contribute must be involved.

Conclusions – a real focus on youth

- Policy makers should address the artificial "chasm" between "child and adolescent" and "adult" services based on age of consent.
- A change of caring teams once a person turns 18 years of age makes no sense when epidemiological research is showing that ages 15-25 years are the most critical years in 80% of all mental disorders.
- These persons need a steady and firm approach that can take them through a life crisis safely.

It is recommended that transition to adult services be postponed to the 25-30 year age group in a flexible approach and only when the person is "ready for transition". The remit of child and adolescent service providers should be extended to cover the early adulthood years – up to age 30 years.

Conclusions – training as a team

- Training of professionals must reflect the growing importance that needs to be given integrating care.
- Professionals must understand development issues linked to youth and understand how to assess and communicate effectively using the language, parlance and methods that are relevant.
- Care must be oriented to offer youth in difficulty with learning and working opportunities.

Professionals within education, health and social services must avoid overlap and learn to work together as a team with the young persons and their relevant others forming part of the same caring team.

Conclusions – research new evidence

- Research must continue to be the provider of evidence.
- Countries would do well to learn from each others' experience, and adapt successful care models and approaches to their own cultural reality.
- There is urgent need to focus on translational research, applying available knowledge into work programmes that can be sustained in the long term.

Issues which need to be addressed in the local context include:

reasons for drop-out rates from educational institutions,

reasons for absenteeism from work,

youth crime, ***sexual abuse,***

migrant or displaced youths seeking refuge or asylum,

youth with LGBTQ issues.

THANK YOU