Mental Health Board

Gibraltar

Annual Inspection Report

2023

Week beginning 23rd October 2023

Ocean Views Mental Health Facility (OV)

Community Mental Health Team (CMHT)

Table of Contents

Table of Contents (contd)

Preface

This will be the Mental Health Board's 5th Annual Report to Parliament since 2019. It hopes that the contents of the Board's findings and recommendations prove useful to the Minister for Health, legislators, clinicians and other stakeholders in the formulation of current and future policy in this key area of our health service.

The following report is neither a critique of the current mental health system nor a celebration of it. It simply tries to give a snap shot in time of where we are and where we should be heading. Where considered appropriate it offers constructive, healthy criticism, which is essential for progress to take place. Platitudes get no one anywhere, nor does negative criticism.

We all make mistakes, as individuals, and organisations are no exception. What distinguishes the mediocre from the great is how we respond to crises and what we learn from them.

The question of mental health pervades every strata of society and knows no boundaries; it does not respect age, economic status or social standing.

Mental health issues can affect anyone at any time, no matter how confident or self-assured that person feels. It inevitably affects the patient's social circle in a very direct and significant way: family, friends and the work environment.

Our mental health services are there for all of us, and as such, we need to ensure that they are the best that they can be.

The Board has been following its journey for five years now and it has seen how under the umbrella of the Mental Health Strategy 2021-2026, a new impetus has been given to the service, which badly needed it.

The objective now is to sustain this trajectory and improve services year on year.

The time frame is established in the Mental Health Strategy 2021 - 2026, however, it is just not enough to have it down on paper, it needs the commitment, and dare we say passion, of all stakeholders to see it through.

It is always easy to criticise those on the front lines that have to deliver the service, and as a community, we often only voice our views when things go wrong. However, we rarely take the time to say, "Thank you for your service".

I would also like to thank my colleagues on the Board, who put up with our long meetings and extended interviews. Without people of the calibre of this team, it would be very difficult to conduct such a thorough inspection, twice a year.

1. General introduction

The Mental Health Act 2016 ("the Act") requires the establishing of a Mental Health Board ("Board") under part 9, Sect. 113 (1) of the Act. Such a Board was established on the 23rd April 2018, under Government Notice No.674 (Appendix A)

The Board currently consists of ten members, one of whom is a registered medical practitioner, two barristers, one retired SRN, two retired head teachers and four lay members with extensive community experience.

The Board is pleased to announce that the Minister for Health ("Minister") granted their request for extra members.

Under Section 115 (1) of the Act, the functions of the Board are to satisfy itself as to the state of the Ocean Views Facility ("OV") at Europa Road and the Community Mental Health Facility ("CMHT") at Coaling Island, and their administration and treatment of patients.

It may enquire into any case, where it appears there may be ill treatment, deficiency in care and treatment or improper detention or reception into guardianship.

As often as it may think appropriate, the Board may visit and interview, in private, patients who are liable to be detained under the Act.

Further, the Board shall bring to the attention of the Minister any matter concerning the welfare of any individual, which it considers ought to be brought to the Minister's attention.

In furtherance to the exercise of its functions under subsection (1), the Board may, under subsection (2), refer cases to the Mental Health Review Tribunal ("MHRT"); interview and medically examine in private, patients held under the Act; and may require the production of and inspect any records relating to the detention or treatment of any person, who is, or has been subject to the Act.

Under Section 116 (1) of the Act, the Board is required to make an annual report to the Minister at the end of each year, concerning its activities, and such report shall be laid before Parliament. As a result, the annual inspection will take place in late September, early October of each subsequent year.

In October 2021, after a change in approach, the new Board decided to draw up an internal interim review for the GHA in order to iron out any issues before the annual inspection.

The first interim review was carried out in October 2021 and presented to the GHA in December 2021.

The Board's second review was carried out in June 2023, with the results presented to the Senior Management Team ("SMT") soon after.

The MHB has met formally on twelve occasions since the Annual 2022 Report and has had countless informal meetings concerning the welfare and running of the Mental Health Services since then.

2. The June 2023 Interim Review

The Board reviewed the Service in much the same way as in the annual inspection; however, there was no written report, just notes arising from the visits and meetings.

This information was then collated and passed on the SMT for discussion with the objective that any areas of concern could be ironed out before the annual inspection in October.

Since it was not a written report *per se*, there was a tendency to concentrate on issues that could be problematic, rather than comment on what was already working in the system.

For the record, the Board would like to state that the progress experienced with the change of managerial responsibilities in 2022 continues to take the service forward. There is much to be positive about and the relationship with the staff has continued to develop with greater involvement and empowerment.

This was documented in our Annual October 2022 report and reinforced in the meeting with the GHA Board on the 16th May 2023.

Admissions to OV are at a record low and the work being done in the community is beginning to bear fruit.

The front line Mental Health Liaison Team ("MHLT") have much to be thanked for this, as are the closer links with the Housing Department and the Care Agency in particular.

The introduction of an Activity Coordinator in OV also continues to pay dividends, with in-patient activities on the increase and more escorted visits organised.

The changes at Gibraltar Young Minds ("GYM") is worthy of note, with a structure, now beginning to tackle historical waiting lists, and with professional input concentrating on tackling problems in the initial stages.

Psychological services have also been re-organised under a new lead and by January 2024, there will be a full complement of Psychologists in post.

The waiting list for psychological and counselling support has been rationalised and it is hoped that historical waiting times will soon be significantly reduced.

Problems with the lack of second doctor to confirm section after hours have been resolved, with the duty Forensic Medical examiner ("FME") attending whenever needed.

There is very good news on the recruitment of locally trained Registered Mental Health Nurses ("RMNs"), with the introduction of a 3-year undergraduate degree from the Gibraltar University. The response has been excellent, and it is scheduled to begin in September 2024.

The Board sees this as a very positive step forward and wishes to suggest that the GHA and Government develop a local succession plan, so that many of our future Psychiatrists, Psychologists and Counsellors can be locally sourced.

There is no doubt that working closely with the two local comprehensive schools will prove fruitful in this respect; it should not be too difficult to encourage students looking to undertake higher education, whether locally or in UK Universities, to consider careers focused on the mental health field of medicine.

The Housing Outreach Team will be given their new roles and responsibilities, which will cement the role they play in supporting individuals within the community. Their role involves interacting with the different agencies and is crucial for patients struggling with daily life. Succession planning in this role is also essential.

Payment to patient facing administrative staff and allowances for nursing assistants on escort duty have finally been approved. This was often a cause of staff discontent and the Board is pleased that these historical issues have been dealt with.

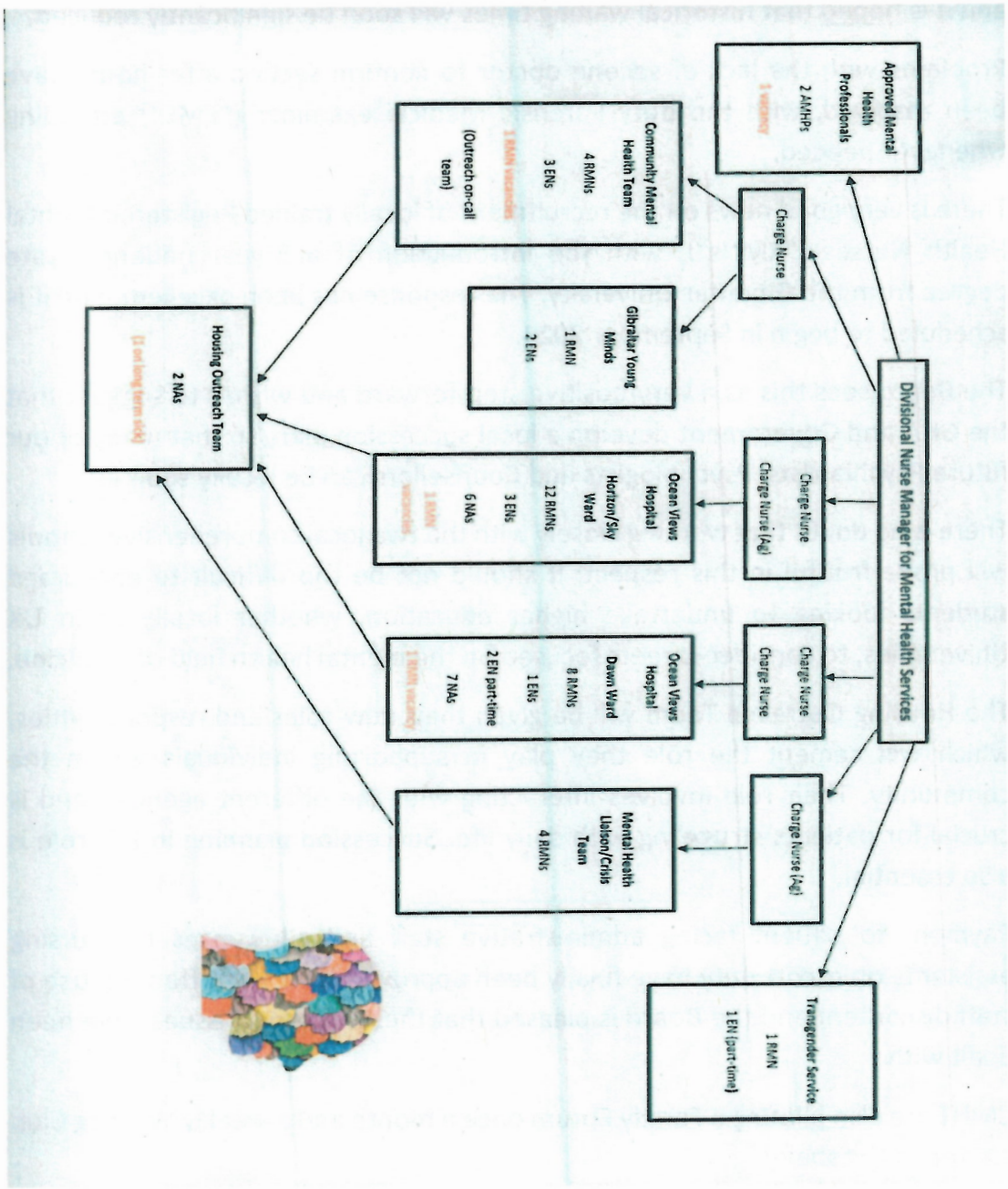
CMHT are also piloting a Family Forum once a month and a weekly Walking Club started in October.

OV now also finally boasts a vehicle, which the Board has been requesting since 2019!

Other more contentious issues, which surfaced in the June 2023 review, will be tackled in their respective sections below.

3. Staff Complement Throughout the Service

Nursing Staffing Complement



Psychiatric Staffing Complement

What service	How much input	Where
Secondary mental health care for just over 400 patients with severe and enduring mental illnesses (Schizophrenia, Bi-Polar etc.)	2.0 Consultant Psychiatrists	CMHT
In-patient service (Horizon Ward, Sky Ward) for patients with an acute relapse of their mental illness (and occasionally for patients 'in crisis')	0.5 Consultant Psychiatrist	OV, Horizon Ward
In-patient (Dawn Ward) and supported home based rehabilitation (Sandpits House, Kent House etc.) for patients with chronic mental illnesses, where their ability to take care of themselves is compromised	0.5 Consultant Psychiatrist	OV, Dawn Ward
Children's Mental Health Services	2 x 0.4 Consultant Psychiatrist	Children's Health Centre and occasionally Horizon Ward and/or Rainbow Ward.
Forensic services to HMP, Courts and MAPPA	1 session per week or as required	HMP or RGP as required/appropriate
Assessment and in-patient detox at OV prior to transfer to Bruce's Farm for rehabilitation	1 session per week	OV out-patients
Support to care agency in respect of residents with severe intellectual impairment who are resident at Dr Giraldi and in the community	1 session per week or as required	Dr Giraldi, community, as appropriate
Cover for psychiatric emergencies in SBH, RGP, HMP, A&E	Monday to Thursday 9AM to 5PM	SBH, HMP, New Mole, community
Clinic for patients who present to A&E in crisis and are not open to CMHT	1 session per week	SBH
Out of hours (24/7) consultant led cover to A&E, SBH, Police and Prison in respect of any psychiatric emergency	128 hours per week	SBH, OV, New Mole, Community

There is also a .5 Psychiatrist undertaking administrative policy tasks who should be re-joining the team shortly

Psychological Staffing Complement

What service	How much input	Where
Primary Care Talking Therapies Approx. 250 patients on caseload/waiting list	1.8 x GHA Counsellors (0.8 via SLA) 1.0 x Counsellor post (interviews pending) 1.0 x Counsellor post pending approval	CMHT, PCC and OV
Secondary Care Talking Therapies Approx. 140 patients on caseload/waiting list	3.0 Psychologists	1 x CMHT 1 x PCC 1 x TBC
In-patient service (Horizon Ward, Sky Ward) for patients with an acute relapse of their mental illness (and occasionally for patients 'in crisis')	0.25 Clinical Psychologist	OV, Horizon Ward
In-patient (Dawn Ward) and supported home based rehabilitation (Sandpits House, Kent House etc.) for patients with chronic mental illnesses, where their ability to take care of themselves is compromised	0.25 Clinical Psychologist	OV, Dawn Ward
Children's Mental Health Services Caseload/waiting list data pending	1.0 Clinical Psychologist 0.4 Counsellor (incl. 0.2 via SLA)	Children's Health Centre and occasionally Horizon Ward and/or Rainbow Ward.
Maternity and Gynaecology Services	0.4 GHA Counsellor	OV
Bariatric Services	0.4 Psychologist (via SLA)	Private clinic
Gender Identity Services	0.3 Psychotherapist (via SLA)	Private clinic
Forensic services to HMP, Courts and MAPPA	Nil	NA
Support to care agency in respect of residents with severe intellectual impairment who are resident at Dr Giraldi and in the community	Nil	NA
Mental Health Liaison Team	Nil	NA

4. Who the Board has interviewed.

Members of the Board spent two days in OV, returning on many other occasions to talk to specific members of staff and patients, who were not available on those specific days.

On another day, some members of the Board visited supported housing in the community. The equivalent of another two days were spent at CMHT, with other visits

The Board also visited GYM, the MHLT as well as HM Prison.

On our visits, the Board spoke to the following:

Activity Coordinator
Administrative Assistants
Carers
CMHT Lead
Community Outreach Nurses
Community Psychiatric Nurses
Counsellors
Dementia Coordinator
Enrolled Nurses (EN)
GYM (RMN & EN)
GYM Multidisciplinary Team (MDT)
Housing Outreach Team
Mental Health Liaison Team
Nursing Assistants (NA)
Patients
Psychiatrists
Psychologists
Psychotherapist
The Prison Superintendent
Registered Mental Health Nurses (RMNs)
The Chief Pharmacist and Pharmacist
The Clinical Director
The Divisional Nurse Manager
The Divisional Site and Services Manager

This does not include incidental conversations held with other staff, patients and other ancillary workers, which have also added to the overall picture.

5. Ocean Views

5(a) General Impression

Although it is eight years since OV opened its doors, the fabric of the building and wards have weathered well.

It is well maintained and it is generally kept very clean, with cleaners at work during the day regularly mopping communal areas as well as the wards.

When entering the building you are met by a receptionist who will attend to your inquiries. There are also security personnel present, who are very helpful, patrol the building and provide much needed help for those trying to park there.

The entrance lobby is large, though somewhat devoid of character. It does not help that the cafeteria is still not operational.

All members of the Board preferred the way it was set up before, since it created a better atmosphere and you could have a coffee and a snack/meal whilst waiting for an appointment or visiting a patient, whereas one is now limited to vending machine facilities. This also provided an element of privacy and anonymity for patients and visitors alike.

Now that the seating area is opposite the main door, it is clear who is anxiously waiting for an appointment.

This is important for those patients waiting and for families coming to see relatives, not just in terms of the appropriateness of the setting but also from the perspective of destigmatisation, which unfortunately mental health issues so dearly need.

When the Board visits the hospital, we always see patients walking up and down the corridors of the wards. They have a large balcony with lovely views, however this is very hot in the summer (greenhouse effect) and is very bright, even in winter and it is not as frequented as one would hope. Perhaps these areas could be reviewed and made more appealing.

There is a small TV room, but that does not allow for the socialising that a larger room would offer patients.

The garden is a very important asset, which is underutilised and needs to be used for other purposes, other than just smoking sessions. It is, however, very hot during many months of the year and consideration should be given to installing some sails or other form of canopy in order to provide extra shade.

5(b) Observations and Recommendations

- ✓ Maintaining a building like OV requires consistent effort and a full maintenance programme. The Board is pleased that this is being kept up.
- ✓ The Board suggests that the entrance be made more user-friendly and inviting, with some imaginative solutions coming from the opening of the cafeteria.
- ✓ The development of the function and facilities at the ARC might be the solution for enabling patients to interact in a setting that is more natural.
- ✓ It should not be too difficult to invest in some blinds along part of the ample balconies to shield patients from the sunlight and mitigate the greenhouse effect during the warmer months.
- ✓ Similarly, consideration should be given to providing extra shading in the garden.

5(c) Patients

It is not always easy to speak to patients, especially as members of the Board are complete strangers and sometimes they are just too ill to engage.

These are just snippets of conversations and information to provide an overview of the profiles and issues raised by patients currently admitted at OV and with whom the Board interacted.

- ➢ Dawn Ward was preparing to discharge two long-standing patients into the community, who would share a flat and would have 24/7 care. It was proving challenging as both had been institutionalised for a long time and seemed perfectly happy to remain on the ward.
- ➢ Likewise, another patient, who had their own Government flat, was reluctant to move back. There had been attempts to integrate the individual into the community, but that had proved unsuccessful up to now.
- ➢ Like the above, one patient was cheerful and happy living on the ward and enjoyed going on outings and listening to music.
- ➢ A patient already living in supported accommodation had become unwell and was recuperating before moving back out. This was taking longer than expected.
- ➢ One patient, who had been very ill, was showing signs that they were improving and responding to treatment. Arrangements were being made to integrate the individual back into the community, albeit slowly.

- All patients enjoyed days out and different activities, though some were not always prepared to engage in physical activities.
- Some patients were only keen on smoking as a form of activity.
- Two patients wanted to know when they were going to be allowed back into the community.
- Many patients wondered why the cafeteria was not open and said they missed it.
- Practically all patients looked forward going to the ARC and engaging in different activities.
- Some complained about the "boring" food.
- One patient was refusing to eat and had to be coaxed into having some food.
- Another patient completely refused to eat anything and wanted to go home.
- There are two patients with learning disabilities as well as two awaiting transfers to ERS.
- One patient complained about being moved to another ward and was not being compliant in their new setting.
- A patient had housing issues and could not move back into the community until that problem was resolved.

5(d) Catering

For in-patients who are living at OV, some for many months and some much longer, the prospect of three daily meals is an important aspect of their lives.

Unfortunately, in hospitals meals very often determine the structure of a patient's day and mark how their time there is spent.

The prospect of looking forward to your lunch or supper fades as the days become weeks and then months and years.

The hospital provides meals direct from the SBH's kitchen and as far as the Board observed, the food provided was of a reasonable quality, although members were told that this varied.

Dawn Ward took their meals in the ARC kitchen.

There was generally little enthusiasm about the food served and it was clear that meal times had become stereotypical with everybody sitting alone at "their" own table and coming up to the counters to choose what they wanted.

At Horizon Ward, the staff were told that the patients could choose their meals, but that these were chosen two weeks in advance. This applied to both wards, although in Horizon, it became more of a hit and miss situation as some patients did not stay that long.

Furthermore, since they were an acute ward, they needed to cater for a full ward, even though they might not have maximum capacity. This resulted in food often going to waste.

During our last review in June 2023, patients had complained about the choice available for breakfast. It was noted that this time round, there had been an improvement in the choice offered.

Every day there was a choice of two items, with porridge and toast as staple. One day a week they would have a cooked breakfast and on another they would have "Churros".

Every Sunday they would also have a roast lunch. There were comments, however that due to its popularity, sometimes there was not as much quantity as they would have liked.

5(e) Observations and recommendations

- ✓ It is not an easy task to vary the menu offered to patients, especially those who have been in hospital for many months or even longer.
- ✓ It might be an idea, the Board thought, to have occasional special event lunches or suppers, which could be announced in advance, with patients having a direct input.
- ✓ Having kitchen facilities in the ARC, it might be an idea every so often to cater for lunch/supper by allowing some patients to plan, buy and cook, under supervision, their own meal for the group.
- ✓ The Board welcomed the improvement in the variety of the breakfasts offered, though it urged the hospital to cater for extra helpings, when there was a popular dish available, like Sunday roast.
- ✓ Some members of staff also commented that healthier food options should also be available, encouraging patients to make wiser choices when moving into the community and maintaining a healthy lifestyle.

5(f) Smoking Culture

In every report, the Board has commented on the issue of smoking, and although there has been some improvement on how this is being tackled, fundamentally smoking is still very much a part of the culture.

Rates of smoking among people with severe mental illness are two to three times higher than among the general population and can reach up to 70% among hospitalised mental health patients.

Consequently, smokers with mental illness experience significant reductions in life expectancy due to smoking-related conditions that are caused or exacerbated by smoking.

Due to metabolic interactions between tobacco smoke and the human liver, smokers with mental illness can require up to double the dosage of psychotropic medication to reach a therapeutic range.

For example in the case of the antipsychotic clozapine, adjustments of dosages might be necessary to prevent potential toxicity.

The Board realises that this issue is not a simple issue to tackle, especially as smoking, as anybody who has ever smoked knows, is addictive and very difficult to stop.

There have been attempts to begin a Smoking Cessation Committee to look into ways of resolving or mitigating this issue, but this has never really got off the ground and smoking is still endemic among most of the patients.

The attempt to encourage patients not to smoke needs to go hand in hand with an active policy to look at the overall well-being of the patient and ensure that they have plenty of exercise and make healthy choices when out in the community.

5(g) Observations and Recommendations

- ✓ Although this is a not an easy issue to tackle, especially as addiction often plays a large part of the reasons why individuals find themselves in OV, it makes perfect sense to resurrect the Smoking Cessation Committee and try to find ways to encourage patients to move away from smoking.

- ✓ It would be useful to find out how mental health facilities in other countries have tackled this problem and how successful they have been in doing so.
- ✓ Anti-smoking aids have now become part of our culture and there is a big push in our community to help the population move away from smoking addiction. Mental health patients, who come under this category, should be encouraged to use these products, both as inpatients and when out in the community.
- ✓ Guidance from the NHS advocates that there should be a dedicated Stop Smoking Lead and staff trained in smoking cessation advice, who can provide behaviour support.
- ✓ It is also important to note that the Court of Appeal has ruled that smoke free policies do not infringe an individual's human rights.

5(h) Activity Coordinator

The Board has met with the Activity Coordinator at OV on several occasions, since the present management cemented the role.

Since 2019, the Board has reiterated the need for patients to have a programme of activities designed to help them cope with their circumstances, empowering and enabling them to lead as normal a life as possible, both as inpatients and out in the community.

Some attempts had been made since 2019 to encourage staff to take on this responsibility, but the uptake had been piecemeal and not sustained.

Fast forward to 2023 and the new impetus given to the importance of activities to improve self-worth and physical health is now embedded in the system.

The Board is very encouraged by these developments, and stresses the importance of continuity and the prioritisation of these services, especially for those whose stay at OV will unfortunately be prolonged.

The Activity Coordinator does not have an official job description or operational policy to go with the role. It is carried out by an experienced part time enrolled nurse, who also has ward duties and carries out Prevention and Management of Violence and Aggression ("PMVA") training.

He works mainly with patients on the Rehabilitation Ward, although there are occasions when he is called to the Acute Ward.

He has drawn up an Activity Programme, which covers the seven days of the week and is re-assessed as and when activities are not possible, or when new ones are added.

The activity ranges from personal budgetary control, through exercise, both in OV and further afield. It also caters for the more artistic in the group and there is time also set aside for the Coordinator to cater for individual needs. The ARC is used for many of these activities.

There are records to ensure that these activities take place, but there are situations that develop in the hospital, like covering in different wards, annual leave, and sickness, which impacts on delivery of the activity at times.

This leads to inconsistency in recording and delivery, which would not happen if there were better oversight to ensure continuity.

A specific job description would safeguard the post and then it would be much easier to make certain that the activities planned for the patients would take place.

The Coordinator is pleased that this aspect of mental health is being given a greater level of importance, but believes that it could be so much better. It would also allow him to tackle the needs of patients on the Acute Ward, which he can only do sporadically at present.

5(i) Observations and Recommendations

- ✓ The Board fully supports the efforts that have been made to encourage patients in OV to take part in planned activities and welcomes the positive emphasis that has been placed on this by management.
- ✓ The Board realises that now that this function has been embedded in the system it needs to take it to a different level altogether.
- ✓ The amount of time that this kind of work takes (planning and execution) requires much more from the Activity Coordinator, if it is to be sustainable in the long run.
- ✓ The Board recommends this post should be made full time and be safeguarded with a job description and an operational policy.
- ✓ It also needs to have a succession policy in place to enable others to step up if necessary.
- ✓ Thus, it will also be possible to develop the activities further and also cater for the needs of patients in the Acute Wards.

5(j) Sampling of Patient Files in Dawn and Horizon Ward

The Board found the state of the patient files very much as they had found them in previous years. They are very detailed, comprehensive and up to date, yet they are still handwritten and legibility becomes an issue with the possibility of errors creeping in, increased.

There is no electronic system in place and therefore everything has to be laboriously written down by all the different professionals attending the patient, with varying styles and levels of legibility.

There is always the possibility of pages being misplaced as these files are constantly being used. Some pages had broken off from the arch-lever file, especially as some of the files were very full.

There is also some duplication, with the same information included in different sections by different entrants.

When a patient is discharged, these files are taken to CMHT to be filed. If that patient is re-admitted to the ward, the file has to be retrieved from CMHT.

5 (k) Observations and Recommendations

- ✓ It is very difficult to understand how an electronic system of note taking has not been introduced to improve patient care and reduce unnecessary duplication.
- ✓ The benefits of such a system would be a game changer for the Service.
- ✓ The Board recommends very strongly that a feasibility study be undertaken to move to an electronic system.
- ✓ The Board has been informed that the reasons OV and CMHT do not use EMIS for electronic reporting is because of confidentiality issues.
- ✓ Surely, this can be overcome by a protected system only accessible by those who deal with mental health patients.
- ✓ The Board believes that such a system was initially proposed when EMIS was first introduced, but it was not followed through.
- ✓ Whether this is done through EMIS or a different system, like RIO, it is clear that it needs to happen to take the Service into the 21st century.

5(l) June 2023 Interim Review

The Board was pleased that some of the concerns expressed by staff in the 2022 Annual Report had been addressed:

- Dawn Ward had increased staff levels and this was impacting favourably on activities.
- Meal allowances were finally being paid for escorts accompanying patients on leave.
- OV now has a vehicle of its own.
- The concern that recruitment of RMNs was getting critical was assuaged by the announcement that RMN undergraduate degrees were being offered by the Gibraltar University, beginning September 2024. (The response to this course has been very encouraging and some of the Nursing assistants we spoke to were interested in taking it up.)
- Management had established contact with a reputable agency, who could provide the necessary RMN long-term cover on a contract basis.
- Patients were using the ARC on a regular basis, but the move of the OTs to SBH had changed its original intended use. (See section on the ARC)

There were however, other concerns expressed in the June 2023 Review that require further updates and are detailed in the following sections.

5(m) Dementia Patients in Ocean Views

The subject of how to deal with dementia patients in OV and the suitability of their placement in a mental health facility has been a source of concern for the staff since our first visit in 2019.

In the June 2023 Review, a case was brought to the Board's notice concerning a person suffering from dementia and their detention in Sky Ward.

The Board will naturally not discuss the specific case details, but it does wish to rely upon this patient's experience to question the appropriateness or otherwise of such an individual's placement in a mental health hospital when they are suffering from dementia.

Patients who have dementia are frightened, confused and terrified of their surroundings if they are not familiar with them. They are often scared of reflections in mirrors and will react aggressively if the frustration and fear becomes too much.

Clearly, a patient like this is best placed in an Elderly Residence Services ("ERS") facility, where their needs can be catered for much more appropriately. A mental health hospital simply cannot offer such a patient the appropriate care, especially as they will be surrounded by some very disturbed individuals who are unable to understand their predicament.

For safety reasons the patient was kept in an isolation suite for many months awaiting transfer to ERS, but that clearly was far from ideal.

The Board was informed that as a result of this unfortunate experience, a direct communication channel was opened with ERS, so that patients who were acutely unwell could be placed in an assessment suite at Trafalgar Wing in Hillside. The care would be provided by Hillside, with OV providing support whenever required. This seemed logical, bearing in mind that Hillside is just a corridor away.

Forward to October 2023 and, unfortunately, bed shortages in ERS have put a stop to this plan and the issue of how to deal with dementia patients in OV remains unresolved.

This is not the first time the Board has encountered problems like these, but hopefully it will be the last.

The Board feels very strongly that there is a need to confront the problem head on and provide the care and proper placement for patients who require specialist treatment that is simply not usually available in a mental health facility and certainly not at OV.

The Board also met up with the new Dementia Coordinator and discussed the issues surrounding dementia and how to treat patients with this condition. She explained that her role involved creating an awareness and an understanding of the condition, and offered training to the mental health services where appropriate in the form of a Tier 2 Dementia training course.

5(n) Observations and Recommendations

- ✓ Sunshine Ward in OV has been closed for over a year and the Board sees this as a possible solution to the perennial problem of how to deal with dementia patients, who need extra support and care for limited periods of time.

- ✓ In the October 2022 Annual Report, the Board highlighted the speculation surrounding Sunshine Ward and urged the GHA to ensure that it was "fully utilised as soon as possible" (Page 13). Unfortunately, today over a year later this asset is still used as a storeroom/training area.
- ✓ The Board proposes that Sunshine Ward be used and ran by ERS, with support from the mental health staff whenever necessary. That frequent and meaningful meetings take place so that protocols are in place and there is compliance with the patients' developing care requirements at all levels.
- ✓ The Board urges all parties to come together and arrive at a workable solution with the minimum of delay, so that Sunshine Ward can become fully operational as soon as it is practical.
- ✓ The Board has mentioned the offer of "Tier 2 Dementia training" to the Mental Health Services and hopes that this can be arranged very soon for front line staff in particular.

5(o) Sky Ward

In June 2023, a concerned family member brought to the Board's attention the sad circumstances of a young individual who had been detained in Sky Ward for many months because of their aggressive nature.

Some time ago, Sky Ward had been deemed not fit for purpose by an internal audit. Unfortunately, there was no other placement available, so they were detained there.

When the Board was informed of the situation, it petitioned management to try to resolve the patient's predicament.

Whilst it did take some time and a change in their treatment regime, they are now in Dawn Ward going out regularly on escorted leave.

5(p) Observations and Recommendations

- ✓ Sky Ward refurbishment is now going ahead and the tendering process has begun. The Board hopes that this is done as quickly as possible for obvious reasons and that sufficient safeguards are put in place to ensure patient and staff safety while the refurbishment takes place.

5(q) Lack of Second Opinion Appointed Doctor ("SOAD")

In the October 2022, the Board was made aware of the difficulties in recruiting a SOAD for the service and that a stopgap measure was being put in place in order to comply with the legal requirements of the Act.

When the Board carried out their Interim Review in June 2023, it discovered that the stopgap arrangement had lapsed, there was no SOAD supervision, and therefore no safeguards were in place to oversee consent to treatment in situations where a patient did not consent to or was too unwell to consent to treatment.

At the time, the Board alerted both the Ministry of Health and the Clinical Director and it was informed that arrangements were being put in place to remedy the situation.

This fact was also reported to the GHA Board on the 16th May 2023.

This October's inspection has found no SOAD supervision in place since at least 2021.

5(r) Observations and Recommendations

- ✓ The Board is very concerned that this crucial safeguard of the service's most vulnerable patients under the Act has not been resolved. It is an integral part of the Act, included to protect both vulnerable patients and medical staff and needs to be resolved as a matter of great urgency.
- ✓ It understands that the recruitment of an independent SOAD is not a simple one. However, the Board feels that, regardless of the difficulty involved, every possible step needs to be taken in order to resolve this.
- ✓ The Board believes that currently it should not be beyond the service to engage a SOAD on a virtual capacity **immediately**, pending a more permanent solution- even if that solution relies on virtual support - given the very limited role for such a professional and the arms-length relationship from the GHA that it requires.

5(s) The Code of Practice

The Code of Practice, which is a requirement under Section 106 of the Act, has still not been delivered to the Service and is now two years behind schedule.

We understand that it is now at a very advanced stage, with a final focus on the relationship between the GHA and other related stakeholders.

This is a crucial document for everyone involved in the delivery of Mental Health Services, as it is the manual that unlocks the Act and offers practical guidance and protocols for all staff to follow when presented with particular situations in the wards or the community.

In 2021, a complete re-write of the code was commissioned, since the previous code was based on a UK version that did not take into account the differences, which were relevant to the local Mental Health Act.

5(t) Observations and Recommendations

- ✓ The Board is aware of the significant exercise that drafting a bespoke Code that fits the Act and the realities of the service in Gibraltar has required; however, it feels that a concerted effort must be made by all parties involved to take this over the line once and for all.

5(u) Ward Clerks

The need for Ward Clerks has surfaced previously in our visits and was highlighted in the presentation to the GHA Board in May 2023.

The introduction of a Ward Clerk, will significantly impact the time that professional staff, Charge Nurses in particular, will have to cater for patients.

Administration jobs and phoning around trying to organise MDTs etc. takes up a significant percentage of their time and can be designated to a Ward Clerk, who would also be available to answer the phone and attend to all queries, whether from other professionals or relatives asking about family members

The introduction of the Ward Clerk would also mirror the other wards in SBH.

5(v) Observations and Recommendations

- ✓ The Board urges the GHA to consider their introduction and carry out a feasibility study to analyse what exactly is required to cover the two wards.

5(w) Junior Doctor

There is also a critical need to recognise and analyse the essential support that Psychiatrists and Psychologists require.

It seems to the Board that the GHA is paying top rates for highly trained and senior professionals to carry out tasks that would ordinarily be undertaken in a supportive role by junior medical staff, rather than dedicating their experience and specialisation to deal with the more complex decision making and aspects of patient care.

The efficiency and benefit to patients derived from such improvements would far outweigh its monetary cost and would help retain professional staff, who are very hard to recruit in the first place.

For the first time, since the Board started in 2018, it looks like the professional complement of Psychologists and Psychiatrists will be at an all-time high starting in January 2024. Something that is worth celebrating.

However, it is the view of the Board that any such structure is unlikely to last unless the appropriate junior support is put in place and the senior medical professionals are allowed to deal with the complex issues for which they are engaged and would ordinarily be expected to deal with.

For example, the Board understands that the compilation and keeping current of patient medical histories, which are fundamental to the care and treatment of mental health patients, is normally carried out by Junior Psychiatrists and Registrars. This structure has never been in place locally. The Board understands that this is often the reason cited for the problems with recruitment and retention of Psychiatrists and the high levels of sickness amongst the existing complement for many years.

5(x) Observations and Recommendations

- ✓ Recruitment and retention of staff, particularly Psychiatrists and Psychologists who are recruited from abroad, are crucial to the development and improvement of our Mental Health Services. One of the most common remarks heard from patients is the lack of professional continuity.
- ✓ The support by Junior doctors would go a long way to enable clinical specialists to carry out their duties more effectively and would ensure longevity of the system.

- ✓ It has often been said that the ratio of Psychiatrists and Psychologists is higher in our community than in the UK, so perhaps there needs to be a re-thinking of how our human resources can be adapted to best suit the circumstances.
- ✓ It is clear that there is a need to evaluate our present system and draw up a plan that both ensures that we retain our clinical professionals and within reasonable levels of expenditure.

5(y) Alcohol Detoxing in Mental Health Facilities

It has been brought to the attention of the Board in meetings with different staff members that alcohol withdrawal can give rise to very serious medical complications – much more serious than in relation to other addictions.

If there is a medical emergency in OV arising from alcohol withdrawal, the patient will have be transferred to SBH since OV does not have the medical facilities to cope with such an event.

Such a transfer, if there is a delay, can potentially result in fatal consequences.

5(z) Observations and Recommendations

- ✓ The Board does not intend to provide medical guidance on this issue, but requests that if using SBH is not possible, then OV needs to have the necessary medical support and equipment to deal with such incidents.

5(aa) The ARC and Cafeteria

The ARC facility is still undergoing fundamental changes and, although it is used daily by patients from Dawn Ward in particular, plans for its future use still need to be finalised.

To our understanding, there are ambitious plans to use it as a hub for in-patients as well as using the open areas for visitors, including a seating area for the cafeteria.

The cafeteria has not yet materialised, but the Board has been informed that the tender has been awarded and it is hoped to be operational in the near future. This development is eagerly awaited.

Included in the plans are offers of supported employment for mental health patients. A very welcome, though long overdue project.

The Board certainly hopes that this happens imminently as the loss of the cafeteria has impacted negatively on patients, visitors and staff since its closure as highlighted before.

5(bb) Observations and Recommendations

- ✓ The ARC is a valuable asset, which should be utilised by all patients and act as the hub for in-patient activities.
- ✓ Plans are on the table to make it precisely that.
- ✓ The Board wishes to impress the importance of a speedy completion, knowing how red tape often delays such projects.
- ✓ The cafeteria is a case in point. It was the heart of OV bringing together patients, staff and relatives. The reasons why it has taken so long to be re-opened escapes the Board.

5(cc) Patient Admission Papers, Medication and Consent to Treatment

All sixteen sectioned patients at Dawn, Horizon and Sky Wards were reviewed on the 7th and 13th December 2023.

Dawn Ward

Patient A was subject to a Hospital Order. Admission papers were in good order. The combination of daily and as required medication prescribed was within BNF limits, appropriate and consistent with their T2 Certificate. This Patient had the benefit of a T2 Certificate, on the basis that the Hospital deemed them able to consent to their treatment. This Patient could not be interviewed by the Board, as they were not at the Hospital. However, the Board members carrying out the visit are very familiar with them and agree that a T2 is adequate given their insight into their condition and their awareness of the medication prescribed.

Patient B was subject to a Section 3 admission. Admission papers were in good order. The combination of daily and as required medication prescribed was within BNF limits and appropriate. On interview, this Patient had no insight into their condition or the original/continuing reason for their admission. This was consistent with the commentary in their H4 Form. They were unable to explain what medication they were was taking. This Patient did not have the benefit of a T3 Certificate by a Second Opinion Appointed Doctor (SOAD), which in the Board's view was required under the Act given their inability to consent to treatment.

Patient C was subject to a Section 3 admission. Admission papers were in good order. The combination of daily and as required medication prescribed was within BNF limits and generally appropriate. This Patient had the benefit of a T2 Certificate, on the basis that the Hospital deemed them able to consent to their treatment. This Patient is well known to the service and the Board and was interviewed. Whilst they could not recall the names of all the medication they were taking, they had sufficient insight into their condition and the purpose of the medication. It was therefore appropriate for this patient to be treated pursuant to a T2 Certificate.

Patient D was subject to a Hospital Order. Admission papers were in good order. The combination of daily and as required medication prescribed was within BNF limits, appropriate and consistent with their T3 Certificate. This Patient had the benefit of a T3 Certificate, on the basis that the Hospital deemed them unable to consent to their treatment. However, the T3 Certificate had not been reviewed for a significant period of time – since 2021. This Patient is well known to the service and the Board and was interviewed. They were unaware of what medication they were taking; albeit was happy to take it and to remain at the Hospital. This Patient did not have the benefit of a current T3 Certificate by a Second Opinion Appointed Doctor (SOAD), which in the Board's view was required under the Act given their inability to consent to treatment.

Patient E was subject to a Hospital Order. Admission papers were in good order. The combination of daily and as required medication prescribed was within BNF limits, appropriate and consistent with their T2 Certificate. This Patient had the benefit of a T2 Certificate, on the basis that the Hospital deemed them able to consent to their treatment. This Patient is well known to the service and the Board and was interviewed. Whilst they could not recall the names of all the medication they were taking, they had sufficient insight into their condition and the purpose of the medication. It was therefore appropriate for this patient to be treated pursuant to a T2 Certificate.

Horizon Ward

Patient F was subject to a Section 2 admission. Admission papers were in good order. The combination of daily and as required medication prescribed was within BNF limits and generally appropriate. This Patient was not interviewed, as there were no concerns regarding their capacity to consent.

Patient G was subject to a Section 3 admission. Admission papers were in good order. The combination of daily and as required medication prescribed was within BNF limits and generally appropriate. Their admission papers confirmed that they lacked capacity to consent and required a T3 Certificate from a Second Opinion Appointed Doctor (SOAD) if this was available. On interview, it was confirmed that this patient lacked capacity to consent not recalling any of the medication being taken or the reason why it was being prescribed.

Patient H was subject to a Section 3 admission. Admission papers were in good order. The combination of daily and as required medication prescribed was within BNF limits and generally appropriate. On interview, it was ascertained that this patient lacked capacity to consent given that whilst they recalled the medication being taken, they disagreed with the need to take it on the basis of a lack of insight into their condition.

Patient I was subject to a Section 3 admission. Admission papers were in good order. The combination of daily and as required medication prescribed was within BNF limits and generally appropriate. This Patient was not interviewed, as there were no concerns regarding their capacity to consent.

Patient J was subject to a Section 3 admission. Admission papers were in good order. The combination of daily and as required medication prescribed was within BNF limits and generally appropriate. This Patient was not interviewed, as there were no concerns regarding their capacity to consent.

Patient K was subject to a Section 3 admission. Admission papers were in good order. The combination of daily and as required medication prescribed was within BNF limits and generally appropriate. This Patient had the benefit of a T2 Certificate, on the basis that the Hospital deemed them able to consent to their treatment. This Patient is well known to the service and the Board and was interviewed. They could recall the names of all the medication they were taking and they had sufficient insight into their condition and the purpose of the medication. It was therefore appropriate for this patient to be treated pursuant to a T2 Certificate.

Patient L was subject to a Section 3 admission. Admission papers were in good order. The combination of daily and as required medication prescribed was within BNF limits and generally appropriate. This Patient was not interviewed, as there were no concerns regarding their capacity to consent.

Patient M was subject to a Section 2 admission. Admission papers were in good order. The combination of daily and as required medication prescribed was within BNF limits and generally appropriate. This Patient was not interviewed, as there were no concerns regarding their capacity to consent.

Sky Ward

Patient N was subject to a Section 3 admission. Admission papers were in good order. The combination of daily and as required medication prescribed was within BNF limits and generally appropriate. This Patient is well known to the service and the Board but was not interviewed because she refused to speak to us.

Patient O was subject to a Section 3 admission. Admission papers were in good order. The combination of daily and as required medication prescribed was within BNF limits and generally appropriate. This Patient was not interviewed because they were sleeping and staff advised us not to wake them up for the purpose of interview only as they were unwell and needed the rest. The Board members are very familiar with this patient's history in their capacity as MHRT members.

Patient P was subject to a Section 3 admission. Admission papers were in good order. The combination of daily and as required medication prescribed was within BNF limits and generally appropriate. This Patient is well known to the service and the Board members carrying out the inspection and was interviewed. This Patient was unwell on the day. However, they had sufficient insight into their condition and the purpose of the medication, knowing that not taking it was very detrimental to their health.

5(dd) Observations and Recommendations

- ✓ Admission papers are completed well and subject to the required timely scrutiny by the facility.
- ✓ The combination of daily and as required medication prescribed was generally within BNF limits, appropriate and consistent with their T2 and T3 Certificates (even if those available are very out of date).
- ✓ The absence of any or any current T3 Certificates in relation to some patients admitted under Section 3 of the Act was of significant concern given that this issue had already been highlighted at the last inspection. The Board is aware that the GHA is actively trying to address the unavailability of a Second Opinion Appointed Doctor, but in the meantime, this essential statutory safeguard is not in place in respect of those patients unable to consent to treatment.
- ✓ It would be helpful for Responsible Clinicians to include an easily identifiable, plasticized memo where the patient's T2 or T3 are usually kept confirming whether they deem a SOAD opinion is required and their reasons for that opinion.
- ✓ Patients subject to Hospital Orders are being actively managed to ensure their progress from a hospital setting to a community setting with controlled attempts at increased levels of independence via escorted and unescorted leave.

6. Community Mental Health Team (CMHT)

The Board found further evidence that the changes, which had taken, place as a result of the Mental Health Strategy and the change in managerial structure was continuing to benefit both the patients and staff.

In contrast to 2021, there are now much fewer cancellations of clinics and there is greater purpose and direction, with clearer objectives and a greater sense of purpose.

The team at CHMT now comprises of one Charge Nurse, four Registered Mental Health Nurses, three Enrolled Nurses, two Consultant Psychiatrists, one Clinical Psychologist, one Counsellor and two administration officers. It also has a part-time social worker integrated into the team for two days of the week

It receives referrals mainly from the PCC, but also from the MOD, MHLT, A & E and private GP practices. It holds daily clinics in psychiatry, psychology and nursing Monday to Friday, including three specialised areas (Clozapine, Lithium and Depot).

There are currently 368 patients under the care of CMHT, much less than in our previous visit. Those patients no longer on their lists have been triaged and moved onto the care of their GP at the PCC, where they will continue to receive their on-going treatment. Many of them were attending CMHT every six months or once a year. It is envisaged that if any of these former CMHT patients need support that this would be forthcoming without having to be referred again.

On average, the CMHT receives about 10 referrals a week and the nursing staff currently each have ninety patients on their caseload. Each referral is discussed in their weekly allocation meeting and triaged accordingly. At the moment, there is a three to four week waiting time to see a Psychiatrist after the triage at the allocation meeting. (Other waiting lists will be discussed elsewhere).

CMHT has established links with the Maternity Department at SBH and is providing psychological and counselling support to their patients. At the time of writing this report, eleven patients have been referred. A member of staff has been identified to act as a link between the two and will ensure that the right support is forthcoming to staff and new mothers. This is a relatively new service and time will tell how well it works.

The question of referrals was also discussed. The Charge Nurse explained the importance of an accurate and detailed referral so that appropriate action could be taken at allocation meetings. He explained the paucity of some of the referrals in the past, with very brief, vague references to the patient's mental health and what steps had been taken at primary level to alleviate their condition. This had a knock on effect on the triage process and could ultimately prejudice the patient concerned, whose plight might not be identified until much later than necessary. This placed some patients on a mental health waiting list, and had the effect of clogging up the system. The situation now is much improved, although there are still some referrals from particular doctors, which require follow-ups due to the referral papers being inadequately completed.

CMHT is piloting a new Referral Form which is documented on EMIS and which should standardise the procedure and allow for a smoother and more comprehensive referral system.

With regards to the move to SBH, the staff were open about their opinions and did state that, although there had been talk of a move at some point, there was nothing concrete and because of previous issues with promises made and not kept, they were reluctant to engage in the consultation process. They looked forward to clear confirmation of a proposed move before re-engaging.

6(a) Issues with the Move to St Bernard's Hospital

In our interim report last June, the Board came across a certain reticence from the staff to move out of the CMHT Coaling Island premises.

They were apprehensive about the move to SBH and the loss of the benefits of an independent service.

Although they accepted that they had to be re-located due to the state of the present building, the dire surrounding area and the on-going works around them, they felt that the move to SBH was not in the interests and the wellbeing of the patients.

They commented that there needed to be a de-escalation area provided for volatile patients, who at some point might need restraining.

They were also concerned about confidentiality and privacy issues and whether patients would see the hospital as a safe haven.

The Board was surprised that they felt they had not been consulted and were very much in the dark about the move to SBH.

Since June 2023, the situation has changed dramatically, especially with the developments during the run up to the general election, where the issue of the move to SBH became a hot topic taken up by both political parties.

When the Board visited CMHT in October 2023, those concerns had been addressed and the move to the hospital was no longer on the table. At least that is what was reported to us.

In conversation with the staff, they expressed approval of this decision and, regardless of the fact that they would remain at the Coaling Island premises for perhaps another two years, they welcomed that a new CMHT facility would be built to cater for the ever-growing needs of the community for this service.

They hoped that this facility would tick all the right boxes and include all the safety features necessary and thereby prove an asset to the community.

6(b) Observations and Recommendations

- ✓ It is not for the Board to opine on the appropriateness of a chosen setting for a CMHT. It leaves that to the clinicians, staff and other mental health professionals who are aware of the requirements of such a facility.
- ✓ The main concern the Board has raised ever since it first visited CMHT in 2019, was the need for its re-location.
- ✓ It hopes that, now that the vision is clear, all stakeholders will work together to deliver the best possible venue and service to our community.
- ✓ That means a transparent, collaborative approach, which ensures that all bases are covered.
- ✓ It also recommends that whatever the facility, adequate human and financial resources be provided so that the service can flourish going forward.
- ✓ It also urges the GHA and Government to make every possible effort to ensure that the move is carried out as quickly as possible, knowing that the present situation is untenable.

6(c) CMHT – June 2023 Interim Review

Since the June 2023 Interim Review, the following has happened:

- Another RMN has been added to the complement.
- A Walking Group has been created.
- The Carers' Group has continued and has grown with guest speakers engaged.
- Lists of patients under "Community Treatment Orders" ("CTOs") are now sent to the RGP on a monthly basis, ensuring that they have the latest information thus reducing unnecessary red tape when a swift intervention is necessary to avoid the situation deteriorating. There are currently nine individuals on CTOs, with the potential of this increasing as the Service looks to treating more patients in the community.

6(d) Matters Pending from the Interim Report

The Depot Clinic has already proved its worth and is continuing to do so. It is a service that can highlight medical issues, which might otherwise not be detected. It has already referred two patients to SBH with potentially serious outcomes.

The main issue is that, although some of the nursing staff are willing to assume responsibility for an element of nursing/medical oversight of other, albeit related conditions at CMHT, this view is not shared by all members of staff.

There are no job descriptions for either psychiatric nurses or enrolled nurses working at CMHT and this makes the establishment of good practices and pathways difficult to implement.

It was also pointed out that with the current caseload of fifty-five patients; it was increasingly difficult to carry out all the necessary observations.

It was suggested that a nursing assistant could be used for this purpose and at the same time cover other areas, like organising MDT meetings, helping with the specialised clinics etc.

The Board informed the SMT and they said that they would look into this. They were not aware of the request but they would follow it up. Furthermore, it was suggested that this situation might be tackled in other ways.

An outstanding issue from the last Annual 2022 Report and the June Interim Review 2023 was the lack of progress on petrol allowance for the use of private transport when carrying out visits in the community.

The Board has been informed that this can now be claimed using specific millage forms.

Another concern expressed was the signal interference experienced by CMHT whenever there is a military ship berthed in the dockyard, which also affects any incoming calls to CMHT.

This no doubt causes great frustration to the staff, but more importantly to any patient or family member who may wish to contact CMHT. This has been known for some time, however the problem remains.

When speaking to a Locum Psychiatrist it was mentioned that there was a need to have a guide for doctors coming over to Gibraltar with regard to residence, health and employment registration and how to go about getting all the necessary documentation in order. It would have made for an easier transition and wasted less time if this had been the case, rather than wade through the bureaucracy of the different Government departments.

Concerns were also raised by the staff when dealing with Sandpits House and untrained Medoc staff who could not manage situations arising from mental health or medication problems, without support from the trained staff at CMHT. This sometimes involved daily telephone consultations on a wide array of issues, which a trained RMN would have dealt with. On some occasions, aggressive patients were causing problems, which made the staff there feel unsupported and vulnerable.

The Board did ask this question of Senior Management and the answer it received was that management was currently addressing the whole model of care.

Digitisation of all mental health records at CMHT began in July 2023 and was suspended in November 2023. (See section on digitisation of records)

6(e) Observations and Recommendations

- ✓ The Board notes the continued positive outcomes observed at CMHT and is confident that, with the goodwill of the staff and the collaborative approach exhibited by management, solutions can be arrived at for the benefit of the patients under their care.
- ✓ It also notes the bridge building that has continued to develop with the Care Agency, the Housing Department and now the Police. This inter agency cooperation is crucial if the service is to expand into and consolidate within the community.
- ✓ The Board recommends that these links are not only maintained, but also enhanced so that all the different departments have a human link to the mental health services. The Care Agency, in particular, has three social workers dedicated precisely to this task.
- ✓ The time has also come to involve other agencies, who at some point may have contact with patients in the community, like for example the Fire Department, whose role sometimes means that they are first on the scene of a potentially tragic situation.
- ✓ The Board welcomes the taking over of the psychological support for expectant mothers and hopes that this develops into other areas of mental health support, which includes the devastating effects of the death of a baby and the often-overlooked loss of a baby through miscarriage.
- ✓ The Board welcomes the introduction of a new referral system on EMIS and urges the GHA management to oversee this and ensure that there is full compliance with the forms so that no time is wasted in treating those who need it most. It further advises that GPs be given sufficient training so that they are aware of the importance of adequate referrals to the patient's treatment pathway.
- ✓ The development of the Depot Clinic is a much-needed service and is crucial in detecting any other medical problems, which mental health patients, by nature of their conditions and medication taken, tend to be very susceptible to and often least aware of.
- ✓ The Board recommends that there is serious consideration in evaluating the needs of this clinic, making the necessary changes to enable it to function efficiently.

- ✓ To this end, it is essential that specialised staff at CMHT be given job descriptions, which truly reflect the job they are carrying out, and to ensure that all areas are sufficiently covered and that the tasks are consummate with their qualifications.
- ✓ The telephone signal interference experienced by CMHT from berthed military warships needs addressing, with both Gibtelecom and the MOD. This situation is unacceptable and can surely be sorted by the technical departments of the parties concerned.
- ✓ The provision of an introductory guide to support the arrival for foreign employees should be prioritised. Once commissioned it can be tweaked as and when needed.
- ✓ The question of supported accommodation run by private companies needs to be re-assessed.
- ✓ If it is to continue then a solution might be to review the contract with the service provider and ensure that the facility is run by suitably qualified RMNs as part of the agreement.
- ✓ The Board urges the GHA to take a decision on this issue and pave the way for a better system of care for the patients concerned.

6(f) Digitisation of Records – On/Off Situation

The digitisation of records has been an on-going recommendation by the Board. It also happens to be one of the seven priorities of the Mental Health Strategy 2021 – 2026.

The efficiency that this will bring to the service is incalculable, since health professionals will be able to access patients' notes at the click of a mouse, as it is done in every other area of the GHA.

The 2021 October Review recommended action to digitise the files at CMHT and the GHA agreed to do this using overtime payments to clerical staff from OV.

The complexity and intricacies of the process meant that progress was slower than anticipated and after a time it was stopped.

The Board did not hear about this until the 2022 Annual Inspection, and it was only at the GHA Board meeting of the 16th May 2023, that it was informed that the process would be recommenced.

This began in July 2023, again via overtime payments.

Unfortunately, because of the nature of the process, the staff had to begin once again to ensure that they had not missed anything since they stopped.

Progress has indeed been relatively slow, but the nature of the task determines the amount of time required to ensure its efficacy.

In order to increase the pace, extra overtime was worked and that much larger claim caused the project once again to be suspended pending review.

6(g) Observations and Recommendations

- ✓ The Board does not wish to involve itself in the internal running of the GHA, but hopes that a speedy and viable solution can be arrived at that will finally achieve the objective of digitising all the mental health files and hopes that the cost will be less than if it had been allowed to finish using extra overtime.
- ✓ Because, when all is said and done, we are all here to ensure that the GHA delivers the best possible service to patients and working from paper files, as currently is the case, is no longer acceptable.

6(h) Clozapine and Lithium Clinics

From our 2019 Annual Report, the Board has been recommending that the Lithium Clinic be subject to the same oversight as the Clozapine one.

The latter is tightly controlled, with medication only prescribed when patients have had specific blood tests. This is an on-going process and determines if the treatment with this powerful and potentially lethal drug is affecting the patient negatively in any way.

This system is overseen by the Chief Pharmacist, who will only dispense the medication when all the necessary tests have been carried out and results assessed.

This operation continues to work very well, and there are no concerns about the process or any of the patients under the auspices of the Clozapine Clinic.

The prescription of Lithium, however, was not subject to the same oversight and the Board has over five years made it a point to request the same level of scrutiny as that of Clozapine.

Over the last two years, the Lithium list has been rationalised and drawn up by an Outreach Nurse in CMHT under the supervision of a Psychiatrist.

The Board's medical representative has seen the list and then checked with the Chief Pharmacist as to any irregularities. There was one query and this was quickly explained to the Board member, who was satisfied with the answer provided.

6(i) Observations and Recommendations

- ✓ The Board is pleased that the Clozapine Clinic continues to work well with its rigorous oversight of patient testing.
- ✓ It is also encouraged by improvements in the testing regime and general oversight of patients under the Lithium Clinic.
- ✓ The Board believes that it makes perfect sense for the Psychiatrist and the Chief Pharmacist to look at the Lithium list periodically to ensure there are no irregularities. It should not be up to the Board to do this every year.

7. Gibraltar Young Minds (GYM)

The Children's Centre continues to flourish. The extra staff and new protocols have dramatically changed the way mental health is responding to the needs of our youth.

Whereas a few years ago there was barely a skeleton staff of two Enrolled Nurses ("ENs") and a Psychiatrist who would visit Gibraltar every so often, the complement has now been increased beyond recognition.

Two locally engaged Psychiatrists now attend at regular intervals with the possibility of remote consultations with a Psychiatrist based in the UK, for specialist advice. The latter comes over every three months for a week to see the more serious cases. This Psychiatrist also remotely attends the allocation meetings once a week, so he is familiar with the caseload. He is also available remotely every Thursday.

A Clinical Psychologist and a Paediatrician are also part of the team who attend these triage meetings.

Also forming part of this team are two Counsellors, who are allocated patients through the same allocation meetings.

Permanently based at the Children's Centre are two ENs as well as a Registered Mental Health Nurse ("RMN").

The latter team deal with the day-to-day running of the Centre and ensure that everything is running smoothly. They also visit schools and have an out of hour's service during the week as well as Saturday and Sunday 9 am to 1pm sessions.

Also present at the meeting are representatives of the Care Agency as well as the Education Department on a needs basis.

Recently a part time Administrative Assistant has been added to the team on a permanent basis and the staff have greatly welcomed this.

Thus, the Allocation Meeting is practically the engine that drives the service, with new referrals and those already on the books, being monitored on a weekly basis.

These meetings decide whether a child has such serious issues that require the immediate support of a Psychiatrist, Psychologist, Counsellor or the intervention of the ENs/RMN.

It might be the case that due to the numbers involved, the ENs and RMN will see and support the children affected until a Psychiatrist/Psychologist/Counsellor can see them. On average, they see about forty-five children a week.

Referrals have increased from three to four a week in 2021, to around ten, but not less than five a week in 2023.

Regardless of this, there is an assurance from the team that if there is a serious concern this will be triaged accordingly in the Allocation Meeting and fast tracked.

All referrals are triaged weekly and designated their respective pathways, with waiting lists for Counsellors and Psychologists having a waiting time of between two to three months, depending on the complexity of their caseloads.

The ADHD waiting list is a cause of concern and has been so now for a number of years. Referrals continue to be made and there is still not enough clarity as to how it is being tackled.

The ASD/ADHD pathway, which was promised, has failed to materialise, a fact that needs addressing as a matter of urgency.

Concerns were expressed at the lack of locally based Behavioural Therapists, with two visiting therapists coming to Gibraltar every six weeks for a two week period and its cost and service implications.

It was also stated that the screening process taking place in the service is reactive as opposed to proactive and there was a suggestion that particular "At Risk" groups could be identified for early intervention.

The MDT had a Child Psychiatrist on a virtual call during the allocation session; however, the two Psychiatrists in the meeting were specialists in Adult Psychiatry. The GHA does not employ a full time Child Psychiatrist, but relies on regular visits from the "virtual" Psychiatrist.

As the service expands, the staff are concerned that room availability is beginning to restrict their clinics. They are advocating for an extra room for a clinic and a suitable office space for Psychiatrists, Psychologists and Counsellors to see patients and parents.

This is often carried out in the Allocation Room, or wherever there is room availability.

The Allocation Room is also very small, especially with so many professionals attending the Tuesday Allocation Meeting.

The expansion of services is also restricted by the need to use spaces like the gym area for group sessions and relaxation classes.

At the moment, there are territorial issues with the use of this facility, which could easily be solved by better communication and more efficient timetabling.

7(a) Observations and Recommendations

- ✓ There is no doubt that the Children's Centre has grown out of all recognition and credit must be given to the management and staff for the impetus it has given Children's Mental Health Services, which were in dire straits, both in funding, human resources and direction just a few years ago.
- ✓ When reviewing the service, the Board notes the enthusiasm and dedication of the staff and their commitment to helping the younger generations with their problems.
- ✓ There is now a much better support service and the protocols are clear when a child presents in a crisis.
- ✓ The follow up is also clearly mapped out and there is plenty of support and communication between the team.
- ✓ Different members of the Board have attended the Allocation Meeting held every Tuesday and there is consensus that it plays a very valuable role in the process.
- ✓ However, the Board did have concerns about the waiting lists. It is all good to have a system in place, but is it having an impact on the time that children have to wait to see a professional?
- ✓ There is a waiting list of two to three months to see a Psychologist and if your child is suffering meltdowns and has acute problems, it is something you do not wish to hear. Every patient on the Psychologist's list will require between six to eight sessions, so it is understandable that there is a waiting list. Mental health issues requires a very different approach and time input.
- ✓ The question then arises, of considering the appointment of an extra mental health practitioner in order to improve access to services, especially as the waiting list for ADHD services is far too long.
- ✓ The latter in particular needs to be tackled by a clear protocol that encompasses Educational Psychologists, general Psychologists, Psychiatrists and Paediatricians, working together to establish a much clearer and specific pathway that ensures smooth running of the service to children, regardless of which area the professionals come from.

- ✓ The ASD/ADHD pathway clearly requires a multidisciplinary approach. Such a pathway would include Occupational Therapy, Speech Therapy, Nutrition, Paediatrics, Schools and the Mental Health Team. Its procedures and protocols need to be clearly mapped out so that everyone is aware of their role and the role that others play.
- ✓ There is some work currently being done on this, but this cannot come soon enough, since the referrals keep on accruing. This needs to be prioritised.
- ✓ The need to recruit local specialists in order to future proof the system is a constant theme amongst staff.
- ✓ It is the Board's strong recommendation that the GHA identifies its future needs and embarks on a process to canvas students currently looking at career options.
- ✓ The need for a locally based Children's Psychiatrist is particularly crucial and would free other professionals to continue working at their specialisms.
- ✓ The idea of a greater proactive approach with the "At Risk" register is one that needs to be explored, with early intervention being key in avoiding greater and more entrenched mental health issues later on.
- ✓ The expansion of the Service clearly requires an equal expansion of the availability of personnel, as well as physical resources.
- ✓ The Board recommends that GYM be given extra rooms to expand their services. It should not be too difficult to find the extra space to fulfil their requirements. The Board notes that there is plenty of available space surrounding the centre.
- ✓ Likewise, the Board is seeking clarity on the challenges related to sharing facilities within the same service. It believes a straightforward timetabling solution can address this issue effectively.
- ✓ The Board strongly recommends that all parties involved should share their requirements during scheduled sessions. By establishing ownership collaboratively, they can explore flexible solutions based on evolving circumstances.

8. Mental Health Liaison Team

The Mental Health Liaison Service was introduced in 2020 supported by two RMNs, who ran a day service.

Such was the initial impact of the service that this has been gradually increased to a 24/7 service covered by five RMNs.

The success of the service has been officially recognised by the GHA in their awards this year and their impact on the Mental Health Services cannot be underestimated.

Since the new re-structure, they have been at the coalface ensuring that mental health patients are treated quickly and effectively, resulting in admissions to OV decreasing substantially.

They are based close to A & E in order to respond immediately to a crisis. They also cater for the mental well-being of the hospital patients at SBH as well as seeing patients who have been in a crisis or are close to one. They also work with OV, the Approved Mental Health Professionals ("AMHPs") and the Police whenever the need arises.

Thus, they are the buffer that stops a crisis developing into something more serious

They work 12 hour shifts and are stretched to provide a 24/7 service, when taking into account annual, sick leave etc. They comment that it is sometimes very difficult to operate with such tight margins.

There is much more they would like to do, like follow up community visits and provide further support, but a lack of human resources does not allow for this at the moment.

The Liaison Team members do not have official job descriptions, or operational policies, thus not allowing the service to function as effectively as it could. It also brings in a certain level of insecurity and opens the way to unwelcome changes in their status in the future.

The team also perform multiple roles that they are required to cover in cases of absences. This removes them from A & E, leaves the service without cover, and increases the backlog when they return.

They understand that this is sometimes inevitable, but the service needs to realise that they are only one and that their removal to another department simply exposes and clogs up the system.

They believe that there is a need for a specialised room in A & E to deal with patients who present themselves in a crisis. They appreciate that space is at a premium, but suggest that a multifunctional suite might be the answer.

8(a) Observations and Recommendations

- ✓ The Board recognises the important work being carried out by the MHLT and recommends unreservedly that the service be expanded to deal appropriately with demand and allow future expansion to service the community.
- ✓ This service has already demonstrated what it can do and its value to the community. For it to move forward it needs to have a clear leadership structure, together with adequate manning levels to enable it to continue to provide a 24/7 service.
- ✓ Furthermore, the role of the MHLT members needs to be recognised with job descriptions, together with a clear operational policy, which is shared with other mental health professionals, so that everyone is aware of their role.
- ✓ It is clear that the service they are providing needs to be supported with a properly equipped multifunctional suite within A & E, in order to ensure the safety of the patient in crisis, the MHLT Officer as well as the other patients and staff in A & E at the time.
- ✓ It should not be too difficult to work together for a solution, which will benefit everyone.
- ✓ They also work from a very small room, with only one entrance, which is very risky if a patient becomes agitated.

9. Psychological Services and Talking Therapies

The Board met with the new Head of Psychological Services and Talking Therapies back in June 2023, when he had just been in post for nine weeks.

It was evident in his interaction with the Board that he was already undertaking a comprehensive revision of the Psychological Services, but he wished to know more about the local dimension and include that in his future plans. After a period of consultation, it was his intention to share his vision and take on board any constructive ideas presented to him.

After the consultation process was over, it was clear that, although laudable, the plan was perhaps a little ambitious, and his vision, though still at its core, was tempered somewhat to reflect the views expressed to him.

The question of recruitment was discussed and it was clear that attracting good candidates to Gibraltar was not easy, but he would do his utmost to fill the two vacant Clinical Psychologist posts.

The conversation also included the need for more Counsellors and how he was actively trying to get some trainee Counsellors to join the service.

Fast forward to October 2023, and the Board is very pleased to note that there will be a full complement of the Psychological Services and Talking Therapies by January 2024.

The service will be composed of the following professionals:

- Head of Psychological Services and Talking Therapies and Clinical Psychologist - at OV - Inpatient services and Adult secondary care talking therapies.

- Clinical Psychologist based at PCC - Adult secondary care talking therapies.

- Clinical Psychologist based at CMHT - Adult secondary care talking therapies.

- Clinical Psychologist based at Child Health Centre (CHC) - Gibraltar Young Minds (GYM)

- Counselling Psychologist (to start in Jan 24) - service and location TBC.

- Counsellor at OV and Child Health Centre (CHC) - Adult primary care talking therapies and GYM.

- Counsellor at CMHT and Child Health Centre (CHC) - Adult primary care talking therapies and GYM.

- Counsellor (part time) at PCC - Adult primary and secondary care talking therapies.

- One trainee Clinical Psychologist (Apr -Sep 24) - Service and location TBC.

- Six trainee Counsellors (all part-time) - Adult primary care talking therapies - various locations.

In order to deal with the waiting lists from 2019 to December 2022, an opt-in exercise was carried out. This is clearly not a perfect system, and the Board hopes that any patients who have not replied, either by choice or inability, should be given an opportunity to latch on to the service, without the need for further referrals.

This legacy list comprises of 136 individuals, whose details have been inputted onto EMIS and GPs will be able to redirect them to CMHT if the need arises.

From January to June 2023, the service triaged around one hundred and fifty individuals who have been placed on a consolidated waiting list for Adult Talking Therapies on EMIS, thus improving oversight and management.

Coupled to that, a weekly referral meeting is held, with all outcomes recorded on EMIS for GPs to view. This new mechanism on EMIS will throw up data on rates of referrals, acceptance and waiting list times. Lack of data in the past has meant that it has been very difficult to see where the service was heading and thus planning for the future proved difficult. This collection of data has just begun, so it still in its infancy, but patterns and trends will begin to emerge as time goes on.

Guidance on referral processes, criteria and thresholds developed will be shared with GPs in CPD sessions, where the latter will be able to discuss the new processes.

Reinvested efficiencies through a SLA review has helped to create a new Counsellor post and Maternity will now fall under the Psychological Services umbrella.

Six trainee placements have now been allocated, with forty-five patients having some level of support much sooner than anticipated.

There is also clinical supervision in place for all staff.

There has been a change of nomenclature, where "Counselling" is now known as "Primary Care Talking Therapies" and "Psychology" will now be known as "Secondary Care Talking Therapies".

The former will involve up to eight sessions in a group or on a one-to-one format informed by Cognitive Behavioural Therapy or person-centred models. Counsellors and/or Assistant Psychologists will deliver these sessions.

Secondary Care Talking Therapies will take up to twenty plus sessions and will be informed by a wider range of therapeutic models. Clinical Psychologists and/or Psychotherapists will deliver these sessions.

The following is the available up to date data for the Psychological Services on the 26th October 2023 from our last visit in June.

- Referred and awaiting clinical triage: 0
- Referred and in clinical triage process: 10

- On Maternity waiting list: 0
- On maternity caseload: 11

- On Primary Care Talking Therapy waiting list: 153
- On Primary Care Talking Therapy caseload: 115

- On Secondary Care Talking Therapy waiting list: 75
- On Secondary Care Talking Therapy caseload: 60

Looking forward there are long awaited plans to have counselling provision at HMP Windmill Hill pending imminent appointments.

Dr Harvey went on to explain his strategy going forward, involving "Away Days" and CPD for the development of the workforce.

He also planned to develop referral guidance, criteria and thresholds for GYM, with all referrals documented on EMIS as well as an improved feedback loop for adult referrals.

He was also considering piloting a triage clinic in the PCC as well setting up group work sessions.

"Talking Therapies" literature for referrers and patients referred would also be made available.

Parallel to all this it was his intention to set up a system-wide scoping and mapping provision across the different agencies.

9(a) Observations and Recommendations

- ✓ The Board is very encouraged by the progress in this area. It acknowledges the fact that for the first time since the Board began reporting in 2019, January 2024 will see a full complement of professionals tasked with dealing with the psychological issues of the community.
- ✓ It is heartened by the way the process has involved consultation with different parties and after that period a clear vision of how the service is intending to progress has emerged.
- ✓ This in no way underestimates the historical issues of waiting times. However, it does point to an awareness that there is a need for action and everything possible is being done to alleviate the situation, while at the same time deal with new referrals.
- ✓ It is early days yet and the gathering of data and assessing the needs of those on the waiting list, could take some time. It is also evident that, regardless of the transfer of patients from this list to their GPs, there might still be a significant number of patients waiting for counselling or psychological services.
- ✓ Unlike medical procedures, as knee and hip replacements or cataract surgery etc., psychological support invariably takes much longer, so the practice of importing medical professionals for intense surgery lists is not applicable to mental health.
- ✓ If at the end of this process waiting lists have not come down to reasonable levels, then it proposes that extra personnel be employed on one-year contracts to specifically deal with this backlog.
- ✓ The Board also welcomes the imminent appointment of a counselling service to the Prison. The lack of this kind of support over the last three years is totally unacceptable. (See HM Prison section)

- ✓ A change of nomenclature always carries with it issues with understanding and can cause confusion. All possible steps need to be taken so that these changes are communicated to the general public, through different media outlets.
- ✓ There is also a need to ensure that the community has faith in the system, especially at the Primary Care level, so that the discussion "want versus need" can be had.
- ✓ It therefore supports the need for "Away Days" and CPD for GPs, since they are the first port of call when someone presents with a mental health issue.
- ✓ The Board also approves the need to work on the referral system, which though improved, still has pockets of individuals whose inadequate referrals can clog up the system. The new referral document on EMIS will hopefully go a long way in eliminating these unhelpful practices and the issues that they give rise to.

10. Counsellors

For the first time the Board talked to three Counsellors working for the GHA Mental Health Services, one of whom is also a Psychotherapist.

The latter had been in the service for eighteen years and was now working part time in the PCC, with a full caseload. She was very concerned about the long waiting lists and wished there was more that could be done.

She explained that dealing with mental health patients was complicated and that it could take quite a number of sessions in order for the patient to derive benefit from them.

She understood the need to rationalise the waiting lists, however she felt that this was simply creating another list and not really tackling the problem head on.

She welcomed the fact that there were going to be two more Counsellors working in the team.

Two Counsellors also carried out Taking Therapies at the PCC, but also worked with the Children's Mental Health Services. They would do twenty clinical hours weekly focusing on children one day and adults the other four. Twenty clinical hours with direct patient-facing work was the limit stipulated by their professional body with the writing of reports, attending MDT meetings and overseeing trainees taking up the rest.

They also viewed the rationalisation of the waiting lists by an opt-in option to be imperfect, but they had to begin somewhere and they felt that at least an attempt was being made to tackle the lists.

There was a very interesting discussion with reference to inappropriate referrals, where the object of the exercise by the patient was to get on the Housing List, for example. These referrals often clogged up the system and probably accounted for about 10% of referrals, when pushed by the Board to provide an estimate.

They hoped the new referral system via EMIS would go a long way in triaging the patients and only allowing through those who actually need to talk to Counsellors.

That a distinction had to be made between "those that want, and those that need".

All were encouraged by the imminent appointment of two extra Counsellors, who they would hope would further reduce waiting times.

They were also pleased about the five local trainees, getting the 100 hours of practice under their belt, but they did stipulate that they also needed to be supervised and that this did take time as well.

They calculated that 45 patients on the waiting list were currently been seen by the trainees.

10(b) Observations and Recommendations

- ✓ The Board is aware that the historical waiting lists need to be reduced and, although the system of an opt-in is not ideal, it is far better than doing nothing.
- ✓ This rationalisation needs to take place, however, it needs to be stated that if any of those patients who did not opt-in for whatever reason felt that they have been done a disservice, they should be allowed to have their case reviewed.
- ✓ The appointment of two extra Counsellors will make a big dent on the waiting lists and alleviate pressure on other services, like GYM and HM Prison.
- ✓ It is gratifying to see local trainee Counsellors taking up the challenge of mental health work and hope that the knowledge and understanding accrued over these months will cement their ambition to work for the service.

11. Supported Accommodation

11(a) Sandpits House

Like on our visit in June 2023, the members of the Board found the house and garden to be satisfactorily maintained with routines well established.

Staff were much happier with the lines of communication and support from CMHT, OV and the Mental Health Social Worker.

They had developed the garage area into a multi-space area for meetings and staff training and they were proposing to turn the room into a cinema-like space for the patients.

There was an individual living in the facility for many months, who was waiting for their house to be re-furbished.

11(b) Observations and Recommendations

- ✓ The Board continues to find a discrepancy between what it sees and hears at this privately run facility with the views of those mental health professionals who deal with their queries and concerns.
- ✓ It is clear to the Board that, though caring and well meaning, the staff at Sandpits do not have the knowledge and training to deal with certain aspects of mental health. Their requests for assistance and support from the service would normally be dealt with by an RMN on site.
- ✓ This point has been made now in numerous reports. When flagged again in June, the SMT explained that the "... the whole model of care was currently being addressed by management." The Board is concerned by the absence of a timeline on this.
- ✓ Until then the Board urges the GHA to examine the contract with this private company and include the provision of suitably qualified RMNs to oversee the facility as part of any agreement in the future.
- ✓ The Board also finds it unacceptable that an individual should be blocking a place in the facility, just because it is taking an inordinate amount of time to make their flat habitable.

11(c) Kent House

The issues with Kent House have been clearly documented since 2019. This time round has been no different.

The flat has undergone repairs and been re-painted on numerous occasions, however, the damp continues to return and the Board considers it not fit for purpose.

11(d) Observations and Recommendations

- ✓ If the Mental Health Service wishes to treat more patients in the community and have more of these flats dotted around Gibraltar, it needs to set in motion a programme of maintenance and quality control, which will determine a baseline for all these flats.
- ✓ In the case of Kent House, it strongly recommends that it should, either, undergo a major refurbishment, or have the patients re-housed.
- ✓ Coupled to this, the Board finds that the sourcing of furniture through donations and charities should be partly phased out and the GHA take financial responsibility to provide basic furniture to kit out the flats.
- ✓ The Board was and is surprised that this flat designated for supported accommodation under the GHA, lacks a budget for basic furnishings.

11(e) Ark Royal House

Members of the Board visited the flat and were shown around by the patient housed there. At the moment, they were living on their own as the other resident had been admitted to hospital.

When members of the Board arrived, the OT was visiting and had just helped the patient cook supper. Before we left, a carer arrived and the patient got ready to go shopping with her.

The patient wishes to have carers at night too, but it was clear that their needs were been sufficiently met at this time. However, that might need to be reviewed if the need arose.

The patient seemed happier than the Board members had seen for some time and they talked about working at Clubhouse and what they wanted to get with their Christmas money.

The flat had recently been painted and was generally in a good state of repair. The furniture in the lounge had been updated and it was looking smarter.

There was a small glass kitchen table, which looked dangerous and needed to be changed.

The bedroom unfortunately lacked a suitable wardrobe that had no doors.

Regardless of this, the patient had been helped to tidy their clothes and they showed pride in what they had achieved.

11(f) Observations and Recommendations

- ✓ The Board was satisfied that improvements to the flat had been made, but it reiterates the comments above reference the budgetary requirements for furniture.
- ✓ It was pleased the individual was doing well and the support network seemed to be working for them. The Board often hears of the support given, but does not often see it in action. Well done.

12. Patients with Chronic Mental Health Issues.

In our visits to OV over the years, the Board has become familiar with patients who unfortunately are admitted regularly to the facility for indeterminate periods of time.

The life of these "revolving door" patients is an endless cycle of crisis after crisis. Of being well for a time, not getting the right support during the better periods and then being sectioned once again to recommence the never-ending cycle.

Much more needs to be done to house and care for these individuals in order to sustain their periods of stable mental health and resulting independence of living for as long as possible. This is very feasible in a community as small as ours is if the right kind of supported accommodation was provided for them to ensure that their needs are catered for.

The Board does not propose the creation of another institution to deal with this. Far from it, but the concept of specialised housing units for two or more individuals, whose needs can be met in the community by the Mental Health Service and other agencies working collaboratively.

The Board has shadowed the CMHT Outreach Nurses and seen patients at home. Some can cope well, but others are just lonely and require company and a purpose in life. The above concept could help alleviate that.

Mental health is a complex, often frustrating area, where, no matter how hard you try; some cases are just so complex to be almost beyond resolution for any sustained period of time.

As a society, we need to give this unfortunate group of individuals the best possible life they can have.

Many in these situations are really victims of society and circumstances beyond their control and understanding. Society has often let them down and when their mental health deteriorates, the community needs to respond pro-actively to their needs.

Mental health requires links to relevant Government agencies. This partnership is crucial. The signs that this is happening are there and the fostering of relationships are essential for further progress.

Case in point is the much closer ties with the Care Agency in particular; there are now three Social Workers working in conjunction with the Mental Health Services as well as one particular Social Worker who for over a year has actually been based at CMHT for two days of the week. We need more of the same.

There are also much better links with the Housing Department and it is becoming more fruitful as the message of helping individuals with mental health issues is brought to the fore.

In our conversations with patients, the Board often finds that mental health issues are exacerbated by patients not being able to access services such as housing, disability payment, rent arrears, renewal of ID cards. Some of them have learning difficulties and practically all of them lack understanding of the electronic means to access such services.

The stresses of these everyday issues greatly impacts their mental health and wellbeing.

12(a) Observations and Recommendations

- ✓ A concerted effort must be made to ensure that these patients, whom everyone knows, can get the necessary kind of support that will make their lives that little bit easier and achieve the greatest possible level of independent living during their periods of improved mental health.
- ✓ The proposal put forward of shared accommodation by the Board should be considered as a way of helping these patients.
- ✓ This way forward requires the support of all Government agencies to work in tandem with the Mental Health Services.
- ✓ Arrangements can surely be made to set aside a desk or person in the Government Egov Hub office to deal with such issues. This would go a long way to ease the mental "burdens" brought about by the often-bureaucratic system in which we live, which is a huge obstacle for individuals with poor mental health.

13. HM Prison visit

A Counselling Service was available to the HMP service until about 3 years ago when the person responsible retired and his post was not renewed.

The service has remained without adequate psychological support for all this time.

It is true that recruitment is an issue, but steps needed to have been taken before to ensure that this gap was filled.

The Board wonders if the issues revolve around who is responsible for provision of the service.

This gap is doing a great disservice to these individual as well as society generally, which will have to bear the cost of their inability to function in the community and, in the short to long term, bear the financial and social costs of re-offending.

If we view prisons as institutions that exist to re-habilitate those who commit crimes, then this situation needs to be tackled with the utmost urgency. Because if we do not then the social repercussions will be with us in an ever ending cycle of crime and prison.

The Prison Service has support from the Care Agency, including MAPA support, a Psychiatrist, the Forensic Medical Examiner ("FME") and a visit from a GP for weekly clinics.

There is also group therapy support from AA on a voluntary basis.

There is, however, no psychological input or counselling service to deal with the mental health issues that accompany individuals when they are incarcerated.

The Board believes that the Prison Service requires the services of Counsellors and psychological input as a matter of urgency.

Whether this is paid for from the Justice or GHA budget is not the concern of the Board simply that the right kind of provision is provided for those who clearly need it.

It also recommends that a feasibility study be carried out to determine what the actual needs are and have in place a pro-rata agreement to increase or likewise decrease support, depending on the needs of the service. Moreover, this should be reviewed regularly.

The Board is aware that steps are being taken to remedy this situation and that once a Counsellor has been appointed it will see a much-improved service.

It understands that a trainee Counsellor will also be working under the direct supervision of the new appointee.

The Board looks forward to these developments, but decries the length of time this has taken to be tackled.

13(a) Observations and Recommendations

- ✓ The delay in appointing a Counsellor to HMP is unacceptable and should have not been left for so long without a solution.
- ✓ The Board knows and appreciates that recruitment has been an issue, but it urges everyone concerned to follow through with the appointment of a Counsellor as soon as possible.
- ✓ The Board urges a much closer synergy between the services and that meaningful discussions take place in order to work out the correct psychological service for prison inmates.

13(b) Breakdown of Protocols

In our visit, the Board was informed of a serious case of someone in Prison, who was exhibiting mental issues, beyond the experience of the staff.

Unable to contact the regular Prison Psychiatrist, they tried and failed to get hold of the Psychiatrist on duty.

In the end, the individual was referred to the FME, who dealt with the case and should have been the Prison's second port of call.

The Board believes that situations like these should not occur, if everyone is aware of the correct protocols.

The situation with this inmate deteriorated to such an extent that what was originally a protest, developed into something more serious. During this time the prisoner received no psychological input and delays in the paperwork meant that the holdup was longer than usual.

Eventually, the person involved was transferred to OV, where he was discharged once his situation was stabilised.

13(c) Observations and Recommendations

- ✓ Once again, it is clear to the Board that there is not enough understanding of the correct actions to follow when such a situation as this occurs.
- ✓ There should be a written protocol to ensure that everyone is aware of the role he or she needs to play in such situations and who is responsible for what.
- ✓ It tasks the Mental Health Services and the Prison Service to work together to re-work and strengthen the existing protocols to ensure that cases, such as confronted the Board, do not happen again.
- ✓ The Board also stresses the need to disseminate such procedures to staff, so that everyone is aware of what needs to be done in particular circumstances.
- ✓ It also recommends that any communication from the Mental Health Services to HMP should be typed out, in order for the recommendations to be clear; a fact which delayed the possible transfer to OV this time round.
- ✓ If administrative support is an issue, then it should be prioritised, or have mental health professionals have access to software , like "Dragon"
- ✓ The Board asked about re-offending as it is relevant to the current issues; however, there are no statistics that they know which covers this.
- ✓ It would be very interesting to have this data in order to make appropriate recommendations.

14. Additional Key Insights and Recommendations

In the course of our comprehensive review of the Mental Health Services, we encountered several pertinent observations and suggestions that, although not fitting neatly into any specific section of this report, merit serious consideration. These insights, drawn from various expert consultations, reflect on the current state of the Service and its potential for future development. They also propose practical solutions to address some of the ongoing challenges. Recognising the value of these insights, we have included a series of recommendations based on these considerations.

The detailed observations and recommendations are presented below:

14(a) Benzodiazepine Use

Gibraltar reportedly has a very high rate of benzodiazepine usage, with approximately 1,200 patients receiving regular prescriptions of benzodiazepines, opiates and z-drugs.

It should be noted that there are challenges in determining the baseline number of GHA users, potentially due to a combination of the following factors:

- Gibraltarians living abroad (either in Spain or further afield), who receive their healthcare in their country of residence but who continue to have a GHA number and are registered in the system.
- Cross-border workers, registered in the system but who may prefer to receive their healthcare in Spain.

Without a clear count of regular GHA users, drawing broad public health conclusions about illness rates, treatment regimens and service needs becomes problematic. The figures relating to the use of these medications need to be viewed in light of this ambiguity in GHA user baselines.

Nevertheless, it appears clear that, in comparison with the rest of the world, there appears to be an over prescription of medications to deal with issues of mental health, even if the exact parameters of that comparison remain unclear. This suggests a potential over-reliance on medication for mental health issues, possibly due to the limited availability of alternative therapies like counselling or CBT; it could be that, were it not for the lengthy waiting lists, GPs would be more willing to refer some of their patients for alternative therapies as the first course of action, exploring medication if counselling/therapy does not have a positive effect.

Moreover, if the benzodiazepine figures are taken at face value, the high prevalence of anxiety disorders in the community is alarming. A comprehensive study to uncover the unique stressors affecting Gibraltar's population could be instrumental in addressing these mental health concerns at their roots.

14(b) Lack of Data or Collection of Feedback from Service Users

There is a perception that GHA staff are reluctant to solicit feedback from service users, or that they only do so selectively and in the anticipation of positive responses.

As previously noted regarding the number of GHA users, drawing accurate conclusions about service quality without sufficient data is challenging.

For the Mental Health services to evolve efficiently, decisions must be based on solid, comprehensive data. This must include insights gathered directly from patients and services users. The GHA should welcome public feedback, including criticism. Embracing honest and constructive input is essential for data-driven improvements tailored to the community's needs.

Thought needs to be given to how this public feedback is to be collected. Possible formats could include public and professional questionnaires, public meetings or smaller focus groups made up of members of the community. However, it is crucial that the collation and subsequent analysis of such feedback is carried out in an open and constructive way that, at the same time, protects individual professionals from unfair or vindictive personal attacks.

14(c) Inefficient Use of Resources

It appears, to the objective observer that many of the challenges faced by Mental Health Services do not stem from a lack of resources per se but rather, from their inefficient utilisation.

There appears to be an inadequate ratio of consultants/senior medical staff to less-qualified mental health professionals to support them (who come at a lower cost to the public purse).

Consultants report a lack of adequate administrative support. This inefficiency results in consultants spending extensive time on administrative tasks, such as writing prescriptions, ordering blood tests, booking appointments, typing letters etc. which detracts from their clinical work and could be carried out just as effectively by staff of a lower level of qualification and, therefore, lower pay

grade. The growth of the service without adequate administrative support is unsustainable.

Furthermore, the services' top-heavy structure results in Consultant Psychiatrists managing cases that could be competently addressed by less-qualified, more cost-effective personnel.

To rectify the suboptimal resource distribution, several practical reforms are proposed which aim to enhance service delivery by optimising the roles and abilities of all staff within Mental Health services:

- Provide Mental Health nurses with the training to write prescriptions, adjusting their job descriptions accordingly. This would free up significant amounts of (costly) consultant time.
- Introduce the role of Physician Associate, a versatile grade that has proven beneficial in the UK. This requires candidates to have a health degree followed by two years of "on the job" training. Establishing this role locally would alleviate consultant's workloads substantially in an extremely cost-effective way.
- In addition, or as an alternative, to Physician Associates, consider increasing the number of junior doctors (trainees from the UK) who would be able to assist the aforementioned nurse prescribers, as well as the consultants, with administrative tasks as well as with the management of less complex cases.
- Allocate administrative staff directly to the wards to handle non-clinical tasks, preventing the poor use of medically trained professionals' time and, therefore, of public funds.
- Continue with the training of primary care workers in Mental Health to enable a system similar to most other countries. GPs would first refer patients with mental health concerns to primary care link workers for triage. These link workers would then determine the appropriate care pathway, whether within primary care, a return to the GP, or onward to secondary care for screening/assessment. Ideally, patients should re-enter primary care after secondary treatment when feasible. Currently, the absence of a robust primary care framework for mental health leads to an overburdened secondary care system, with consultants having limited options for patient referral once they consider that secondary treatment is no longer necessary.

14(d) Budget

In a small community, there exists the unique opportunity to create a nimble and interconnected system within public services, especially in the realm of mental health. Unfortunately, the current operational structure tends to inhibit rather than facilitate this ideal scenario.

One significant hindrance is the way budgetary control is exercised. Mental Health services has a substantial staff of approximately 100 members, yet these professionals do not have jurisdiction over their own budget. This disconnect means that the dedicated individuals who are most familiar with the intricacies of the service do not have the authority to allocate financial and human resources effectively. As a result, any attempt to advance or refine the service becomes a protracted and laborious process.

For the service to truly thrive and improve, those who operate it daily need to be given significant input into how the budget is utilised. In an ideal world, those at the helm of Mental Health Services would be given the autonomy to determine how their budget is spent, enabling them to make informed and responsive decisions.

However, if budget control must remain centralised, which we assume is the case, then it is crucial that the decision-makers heed the advice and recommendations of Mental Health staff, who possess the hands-on experience and knowledge to know where resources would be most impactful. Furthermore, the process via which their advice is sought and then followed should be swift, providing the service with the agility it requires to respond to ever-changing demands and to improve in line with the observations and experience of Mental Health staff on the ground.

Adding to the challenge is the apparent absence of a designated role for identifying and addressing wastage within the GHA generally; a problem that is both significant and pervasive. It is not merely a matter of resource quantity; it is the efficacy of resource utilisation that is of concern. Without someone to systematically evaluate and rectify inefficiencies, resources that could be used to enhance patient care and service delivery are instead squandered.

Currently, the staff within Mental Health services find themselves in a paradoxical situation where they are burdened with the disadvantages of both an independent and an integrated service, without the advantages of either. They face the bureaucratic obstacles typical of a separate entity, such as lack of budgetary control, while simultaneously contending with the inefficiencies that

come with being part of a larger, more unwieldy system. This leaves them in a liminal state; without the autonomy that should come with independence, nor the streamlined processes that integration could offer. It is a position that fosters frustration and stymies progress, calling for a critical reassessment of the structural relationship between the Mental Health Services and the overarching administrative body of the GHA in order to empower the dedicated staff and improve service delivery.

14(e) Meaningful Integration of Care Services

Not only is it important to reassess the structural relationship between Mental Health Services and the wider GHA, but it is also worth considering whether there should be greater integration between Mental Health and other care services in the community, such as social care.

Before exploring this notion further, it must be acknowledged that significant steps in this direction have been taken since the matter was first raised in 2019, when there appeared to very little synergy between Mental Health Services and any other government department. Today, the Care Agency has three social workers who collaborate closely with CMHT and OV one of whom is deployed in CMHT for two days of the week. The service has commendably developed a Housing Outreach support system to aid patients transitioning from Dawn Ward and to assist other individuals facing challenges living independently within the community.

However, it is increasingly evident that additional resources are crucial, especially concerning supported accommodation. For example, a glaring gap is the apparent lack of a budget for furnishing these properties, compelling Housing Outreach to rely on charities and goodwill, with the unpredictability that this entails, for sourcing furniture.

Most critically, as the service pivots towards treating more patients within the community (a move that aligns with a progressive vision of healthcare) the need for a more integrated approach becomes paramount. This integration should seamlessly encompass mental, physical and social care, ensuring a holistic support system.

For a practical example of how this can be applied, one can observe the steps taken by the Greater Manchester Mental Health NHS Foundation Trust to offer "whole person" care that addresses mental, physical and social needs. By bringing services together, the initiative seeks to improve the coordination of care, making it easier for patients to access the support they need. It also aims

to reduce the stigma associated with mental health and to promote mental well-being across the population.

A practical first-step in this direction would be to build on the review that has already been commenced of the scope and function of the entire Mental Health Service; what is it that they do and, perhaps more importantly, what it is that they do not do. Within such a review, the boundaries of the Mental Health Service can be defined in order for agreement to be reached on how the service should work with external agencies and groups, including the Justice Ministry (HM Prison, the Court Service, the RGP), the Housing and Education Departments, the voluntary sector and last, but not least, the rest of the GHA (in particular ERS, Paediatrics, Primary Care and Emergency Services).

In the close-knit weave of a small community such as ours, increased inter-departmental communication together with the integration of Mental Health services with social care could herald truly transformative change, weaving together the threads of psychological support and social welfare into a cohesive fabric of care.

Such an alliance would likely streamline the often-complex path to accessing services, clearing obstacles and setting the stage for more timely and pre-emptive support. This proposed integration could enhance communication between service providers, leading to a collaborative approach that is both sensitive to cultural nuances and adept at resource management.

The community itself, within this hypothetical integrated system, could become an active participant in promoting health, helping to reduce stigma and creating robust support systems, and fostering an environment where early intervention becomes the norm, not the exception. Public awareness initiatives and outreach would likely engage residents, informing them and encouraging them to take an active role in mental health advocacy. This could lead to the further strengthening of peer support groups, where individuals with personal experience in mental health challenges provide support to others. More volunteers from within the community might offer their time to support the services, whether through administrative tasks or direct support to those in need.

Such integration also opens avenues for community feedback to influence service development, ensuring that the services on offer meet the actual needs of the community. Local training programs could be developed, leading to job opportunities in mental health and social care such as those discussed above, which would further entrench these services within the community. With a

hands-on approach, resources could be directed more efficiently, with the community playing a crucial role in identifying and addressing its own needs in a concrete and forward-facing manner.

In essence, the blending of mental health services and social care in Gibraltar should not merely be an administrative reform; it should involve the cultivation of an ecosystem where every individual is seen, supported, and strengthened and where comprehensive health needs can be more effectively acknowledged and met. One can only imagine the transformative impact on our community's wellbeing when individuals receive comprehensive, coordinated care. Greater allocation of resources towards making this vision a reality would not only be an investment in the healthcare system – it would be a commitment to a healthier, more vibrant future for all Gibraltarians.