# National Suicide-Prevention Strategy for Malta

2025-2030

GOVERNMENT OF MALTA
MINISTRY FOR HEALTH
AND ACTIVE AGEING

## Help Is Available

Thinking, learning, reading, and talking about suicide can be distressing. If you feel distressed, you should be aware that help is readily available. If you need help, please access the support that you need.

There is no shame in voicing your worries and hardships.

## 24/7 Services

**National Mental Health Helpline**
For suicidal thoughts, mental-health problems, loneliness, and emotional support.

Call the National Mental Health Helpline **1579**

**Foundation for Social Welfare Services Supportline**
For domestic violence, abuse, homelessness, and drug, alcohol & gambling problems.

Call freephone **179**

**Emergency Services**
For ambulance, police, and civil protection services.

Call freephone **112**

**The Emergency Psychiatric Service**
For emergency psychiatric reviews and assessments by doctors and nurses specialised in mental health.

Accessible through the Accident & Emergency
Depar ment at Mater Dei Hospital, Msida

**Suicide Prevention Outreach and Therapeutic Services (SPOT)**
SPOT provides support to people who have been affected by suicide (bereaved individuals), people who have attempted suicide three months prior to service intake, and people who struggle with suicidal ideation.

Visit https://victimsupport.org.mt/spot/ for more information or contact Victim Support Malta on +356 2122 8333 or info@victimsupport.org.mt

This strategy was developed for National Mental Health Services, under the auspice of the **Ministry for Health and Active Ageing**, by local delegates from Work Package 6; a working group of the **Joint Action ImpleMENTAL** on the Implementation of Best Practices in the areas of Mental Health and Suicide Prevention.

## Acknowledgments

Our profound gratitude to all who contributed to this National Suicide Prevention Strategy – your stories, dedication, and expertise inspire hope and change. Together, we affirm the value of every life and our shared commitment to a supportive, connected society.

*The CEO and Staff*
*National Mental Health Services*
*Ministry for Health and Active Ageing*

## Dedication

**Every life lost to suicide is a life too many.**

This strategy is dedicated to

all the persons who lost their lives to suicide,

all the persons who have tried ending their lives,

all the persons who contemplate ending their lives,

all the persons who lost their loved ones to suicide.

# Contents

# Foreword

## The Hon. Dr Jo Etienne Abela

**MD MRCS FRSCEd MPhil FEBS MP**

**Minister for Health and Active Ageing**

It is with great significance that we present Malta's first National Suicide Prevention Strategy. This strategy builds upon the framework established by the Mental Health Strategy for Malta 2020 - 2030, which underscored the Government's commitment to prioritizing the mental health and wellbeing of our population.

Designed to be implemented over the next five years, this strategy addresses both evolving and emerging challenges, reflecting the realities we face on local and global levels. While Malta registers one of the lowest suicide mortality rates in Europe (ranked second alongside Greece in 2017), it is essential to recognize that every life lost to suicide is a profound tragedy. The repercussions extend beyond the individual, leaving a lasting impact on families, friends, and the broader community. Preventing suicide is a collective responsibility, necessitating a comprehensive, whole-of-government, and society-focused approach.

Government remains steadfast in its dedication to the wellbeing of all individuals, offering a robust network of crisis intervention services. These include the 24/7 Emergency Psychiatric Service accessible through the Accident and Emergency Department at Mater Dei Hospital, the Crisis Resolution and Home Treatment Team, the Crisis Intervention Home Treatment Service for children and adolescents, and the 1579 Helpline.

A key milestone in this commitment is the provision of integrated, person-centered care to enhance access to mental health services and achieve optimal health outcomes. Plans are underway to establish a new Acute Psychiatric Unit (APU) within the perimeter of Mater Dei Hospital to cater for individuals experiencing acute mental health challenges. Additionally, a dedicated psychiatric area within the Emergency and Accident Department at Mater Dei Hospital will ensure efficient and appropriate management of psychiatric emergencies. In further support, Specialists in Family Medicine have been empowered with prescription rights for anti-depressant and anxiolytic medications and will receive comprehensive training to better address mental health needs within the community.

This strategy has been developed with care, guided by evidence-based research and richly informed by the experiences and narratives of those affected by or bereaved by suicide, to whom we extend our heartfelt gratitude. Let this strategy serve as a beacon of hope for individuals facing mental health challenges, emphasizing that support is readily available. There is no shame in seeking help.

## Public Consultation

The Ministry for Health and Active Ageing has produced the National Suicide Prevention Strategy 2025-2030. This strategy is a first for Malta and was produced as one of the deliverables of the participation of the National Mental Health Services in the Joint Action ImpleMENTAL. In drafting the Strategy, the National Mental Health Services conducted meetings with a purposely constituted Advisory Board made up of experts coming from different ministries and sectors. Additionally, a pre-publication consultation with over 40 key stakeholders, including various ministries, entities, Non-Governmental Organisations (NGOs), and individuals bereaved and/or affected by suicide was held. The strategy is being put forward for a wider consultation process and we look forward for your submissions.

### Consultation Period

The general public and civil society organisations are invited to provide feedback on the measures proposed in this initial consultation document on the dedicated portal: **publicconsultation.gov.mt**.

Submissions can be made on the feedback form available on the same portal.

Your contribution will ensure that this strategy provides the necessary guidance and actions to empower patients with mental health difficulties, provide a supportive environment, and continue to develop person-centred care responsive to their diverse needs.

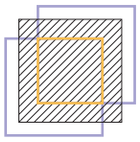
## Executive Summary

Suicide is a significant and complex public health problem which claims the lives of over 700,000 persons annually (WHO, 2021). Suicides are preventable. There are several measures that can be taken at population, sub-population, and individual levels to prevent suicide and suicide attempts. The reduction of suicide mortality has been prioritised as a global target by the World Health Organization (WHO), after being outlined as an indicator in the United Nations' (UN) Sustainable Development Goals under target 3.4 (UN, 2017), in WHO's Thirteenth General Programme of Work 2019–2023 (UN, 2017) and in the WHO Mental Health Action Plan 2013–2020 (WHO, 2013). Through the establishment of such targets, the WHO aims to prevent the tragedy of suicide from persisting to permeate the lives of millions of individuals through the loss of loved ones (WHO, 2021).

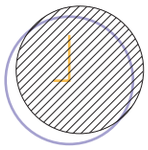
This is the first National Suicide Prevention Strategy for Malta, which has been produced by National Mental Health Services, under the auspices of the Ministry for Health and Active Ageing, in collaboration with valued stakeholders from several disciplines. The inclusion of experts by experience in the consultation process has deeply enriched the meaning and direction of this strategy. Consultations with professionals and agencies from the areas of health, mental health, social welfare, education, law enforcement, the media, and marginalised groups have provided a comprehensive vision for extensive suicide prevention and early intervention efforts.

This strategy builds on the principles and actions underpinning the Mental Health Strategy for Malta 2020-2030 (Ministry for Health, 2019), which commits to a whole-of-government approach towards suicide prevention. This strategy is planned over a five-year period until 2030, given the rapidly evolving facade of our national population and its implications for mental healthcare, keeping in context our increasing multiculturalism and varied post-COVID-19 effects.

# The successful implementation of this strategy involves



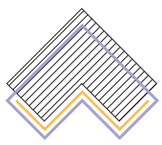
Joint activities and cross-boundary collaboration performed by diverse ministries, public agencies, and voluntary organisations to provide a comprehensive plan of action for National Suicide Prevention.



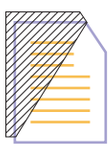
The provision of timely and sufficient support and treatment to persons at-risk of suicide, and their caregivers.

Gatekeeper training, robust emergency and stabilisation services, and targeting of high-risk groups. These strategies are complemented with strategies geared at further restriction of suicide means.

Improved societal awareness and mental health literacy.



Enhanced efforts in mental health promotion and prevention activities.



Amelioration of data collection practices and the publication of a yearly report on suicide mortality to inform future policies, programmes, and services.

# Definitions

**Suicide**

The Centres for Disease Control and Prevention (CDC) defines suicide as “death caused by self-directed injurious behaviour with an intent to die as a result of the behaviour.” (Crosby et al., 2011)

**Suicidal Ideation**

The CDC refers to suicidal ideation as “thoughts of engaging in suicide-related behaviour”, which may include thinking about, considering, or planning for suicide (Crosby et al., 2011).

**Suicidal Intent**

The CDC refers to suicidal intent as “the existence of evidence (explicit and/or implicit) that at the time of injury the individual intended to kill oneself or wished to die, and that the individual understood the probable consequences of their actions.” (Crosby et al., 2011)

**Suicidal Plan**

The CDC refers to a suicidal plan as “a thought regarding a self-initiated action that facilitates self-harm behaviour, which includes an organised manner of engaging in suicidal behaviour, such as a description of a time frame and method.” (Crosby et al., 2011)

**Suicide Attempt**

The CDC defines a suicide attempt as “a non-fatal self-directed potentially injurious behaviour with an intent to die because of the behaviour, which may or may not result in injury.” (Crosby et al., 2011)

**Non-Suicidal Self-Injury (NSSI)**

The CDC defines NSSI as a “behaviour that is self-directed and deliberately results in injury or the potential for injury to oneself”, without implicit or explicit evidence of suicidal intent (Crosby et al., 2011). Common examples of NSSI include cutting, burning, scratching, banging or hitting, and most people who self-injure use multiple methods (Klonsky et al., 2014).

**Intentional Self-Harm**

“Intentional self-harm is often defined as deliberately injuring or hurting oneself, with or without the intention of dying. Intentional self-harm comes in many forms, and affects people from different backgrounds, ages and lifestyles. The reasons for self-harm are different for each person and are often complex.” (Australian Institute of Health & Welfare 2024)

# List of Acronyms

**A&E**
Accident and Emergency

**AMSR**
Assessing and Management of Suicide Risk

**CDC**
Centres for Disease Control and Prevention

**ĊTC**
Ċentru Tommaso Chetcuti

**CAPES**
Child and Adolescent Psychiatric Emergency Service

**CYPS**
Child and Young People's Services

**CAYS**
Child, Adolescent and Youth Services

**CSDH**
Commission on Social Determinants of Health

**CMHTs**
Community Mental Health Teams

**CTO**
Community Treatment Order

**CSA**
Correctional Services Agency

**CRHT**
Crisis Resolution Home Treatment

**CIHT**
Crisis Intervention and Home Treatment

**DKGS**
Dar Kenn Għal Saħħtek

**DHIR**
Directorate for Health Information & Research

**ECT**
Electroconvulsive Therapy

**ECS**
Electronic Case Summaries

**EPS**
Emergency Psychiatric Service

**EHIS**
European Health Information Survey

**ESPAD**
European School Survey Project
on Alcohol and Other Drugs

**EU**
European Union

**FSWS**
Foundation for Social Welfare Services

**GGH**
Gozo General Hospital

**HPDP**
Health Promotion and Disease Prevention Directorate

**KGH**
Karin Grech Hospital

**KPIs**
Key Performance Indicators

**LGBTIQ+**
Lesbian, Gay, Bisexual, Transgender, Intersex and Queer

**MAOT**
Malta Association of Occupational Therapists

**MAPN**
Malta Association of Psychiatric Nurses

**MAP**
Malta Association of Psychiatrists

**MCP**
Malta Chamber of Psychologists

**MCAST**
Malta College for Arts, Science and Technology

**MGRM**
Malta Gay Rights Movement

**MPPB**
Malta Psychology Profession Board

**MDH**
Mater Dei Hospital

**MHA**
Ministry for Health and Active Ageing

**MCH**
Mount Carmel Hospital

**MDTs**
Multi-Disciplinary Teams

**NCISH**
National Confidential Inquiry into Suicide and Homicide by People with Mental Illness

**NHIS**
National Hospitals Information System

**NMHS**
National Mental Health Services

**NSSS**
National School Support Services

**NGOs**
Non-Governmental Organisations

**NSSI**
Non-Suicidal Self-Injury

**OECD**
Organisation for Economic Co-operation and Development

**PLS**
Psychiatry Liaison Service

**RAWA**
Recovery and Wellbeing Academy

**SVPR**
Saint Vincent De Paule Residence

**SOGIGESC**
Sexual Orientation, Gender Identity, Gender Expression and Sex Characteristics

**SMR**
Standardised Mortality Rate

**SDGs**
Sustainable Development Goals

**TMS**
Transcranial Magnetic Stimulation

**UN**
United Nations

**WHO**
World Health Organization

**YPU**
Young People's Unit

# 01 Introduction

**Suicide is a significant and complex public health issue which claims the lives of over 700,000 persons annually (WHO, 2021).**

**It is amid the leading causes of death worldwide, particularly among 15- to 29-year-olds, among whom suicide remains the second leading cause of death (WHO, 2021).**

Given the persistent global burden of suicide, the United Nations' Sustainable Development Goals (SDGs) have incorporated targets in relation to suicide. Goal 3 of the SDGs is to "ensure healthy lives and promote wellbeing for all at all ages". Furthermore, Target 3.4 of the SDGs aims to reduce one third of premature mortality from non-communicable diseases by 2030, through prevention, treatment, and the promotion of mental health and wellbeing. Within Target 3.4, suicide rate is an indicator (3.4.2) (UN, 2017).

It is estimated that there are more than 20 suicide attempts for each suicide death (WHO, 2021). A World Health Organization study by Nock et al. (2008) estimated the cross-national lifetime prevalence (standard error) of suicidal ideation, plans, and attempts at 9.2% (0.1), 3.1% (0.1), and 2.7% (0.1), respectively. Across all 17 countries participating in this study, 60% of transitions from suicidal ideation to suicidal plan and attempt occurred within the first year after ideation onset.

In 2020, there were 47,252 deaths due to intentional self-harm in the EU, corresponding to 0.9% of all deaths reported that year. This is the equivalent of an average of 10.2 deaths per 100,000 population. On average, there were almost 11 deaths per 100,000 inhabitants resulting from suicide in the EU in 2016.

In 2017, among the EU Member States, Malta and Greece had the second lowest standardised death rate for suicide (both 5 deaths per 100,000). Cyprus had the lowest standardised death rate (4 deaths per 100,000 inhabitants) whereas Lithuania registered the highest rate of suicide at 26 deaths per 100,000 inhabitants (Eurostat, 2020).

Non-suicidal self-injury (NSSI) is another suicidal behaviour that is most common among adolescents and young adults. A recent meta-analysis by Xiao et al. (2002) showed that NSSI is associated with higher global lifetime prevalence (of up to 22.0%) among younger populations. Lifetime history of NSSI has consistently been linked to heightened suicidal risk (Grandclerc et al., 2016), with research among younger populations indicating a three to four-fold increase in the probability of a suicide attempt (Szmajda et al., 2023; Hamza & Willoughby 2016). In both adolescents and adults, rates of NSSI are highest among psychiatric populations, particularly people who report characteristics associated with emotional distress, such as negative affectivity, depression, anxiety, and emotion dysregulation (Klonsky et al., 2014).

Suicide may produce a 'ripple effect', due to its widespread impact on the whole community of the bereaved individual. However, the people affected most dramatically are those closest to the person who died by suicide (i.e. family, friends, co-workers, and/or classmates).

People with suicidal behaviour do not often seek help since suicide is a subject often shrouded in stigma, shame, and misunderstanding (WHO, 2019). There are many stereotyped and stigmatised beliefs surrounding the subject of suicide. A list of myths and facts about suicide are found in Appendix 1. The UK National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH, 2018) as well as systematic and meta-analytic studies (Walby et al., 2018; Stene-Larsen & Reneflot, 2017; Luoma, 2002) show that only one quarter to one third of people who die by suicide have been in contact with National Mental Health Services in the year prior to suicide death. Contact rates with primary healthcare are higher, measuring between 45% (Luoma, 2002) and 80% (Stene-Larsen & Reneflot, 2017). However primary care clinicians are at significant risk of under-detecting suicide risk since they are rarely prompted to screen for suicide when the presenting complaint is of a medical nature (Osborne et al., 2023; Horowitz et al., 2009).

The estimated financial and economic burden of suicide varies depending on the region, methodology, and scope of the research studies. However, studies consistently indicate that suicide imposes substantial costs on society. Direct costs typically include healthcare expenditures related to medical treatment, emergency response, and coroner services. Indirect costs encompass productivity losses due to premature death, decreased workforce participation, and the ripple effects on families and communities (Segar et al., 2024).

Doran & Kinchin (2014) delved into the impact of youth suicide by assessing years of life lost, years of productive life lost, and the economic value of lost productivity. In their 2014 study, they found that an estimated 6,912 young people residing in the most developed countries in the world lost their lives to suicide. These preventable deaths resulted in a loss of 406,730 years of life and a cost of $5.53 billion in lost economic income, with the average cost of suicide estimated at $802,939 per person per country.

Additionally, a study conducted in Ireland by Kennelly (2007) estimated the economic cost of suicide to be over €906 million in 2001 and over €835 million in 2002 (in 2001 prices). This is equivalent to a little under 1% of the gross national product in Ireland for those years. More recently in France, Segar et al. (2024) concluded that the total costs and burden of suicides and suicide attempts were estimated at €18.5 billion and €5.4 billion, respectively, excluding costs related to caregivers' burden. Direct costs were estimated at €566 million and €75 million, respectively, whereas indirect costs were €3.8 billion and €3.5 billion, respectively. The researchers suggest that public health interventions related to suicide prevention could potentially reap major savings.

Research related to the etiopathogenesis of suicidal behaviour is substantial and various predictive and theoretical models have been proposed (Díaz-Oliván et al., 2021). The WHO (2023) and the Centres for Disease Control and Prevention (CDC) (2021) have delineated various biopsychosocial and economic factors which heighten suicide risk. However, it should be acknowledged that risk factors amplify suicide risk for a whole population across the life-course, but do not predict individual suicides at any given point in time (Royal College of Psychiatrists [RCPsych], 2020). This is largely because of the relatively rare occurrence of suicide (Wasserman 2016; Gibbons 2013) and the consequent low positive predictive value of the risk factors for suicide (McHugh et al., 2019; Carter et al., 2017).

The WHO hence advises that the prevention of suicide cannot be accomplished by persons or organisations working in silos. Rather, suicide prevention requires support from the whole community since the community itself is best placed to identify local needs and priorities. Communities are able to offer support to at-risk persons and their families, raise awareness and fight stigma, thereby reducing suicide risk and reinforcing protective factors. Furthermore, communities foster a sense of belonging and protect at-risk persons from suicide by building social connectedness and nurturing adaptive coping strategies (WHO, 2019; Coppens et al., 2014).

Considering these striking facts, suicide is perceived as preventable, particularly when comprehensive and multisectoral suicide prevention strategies are in place (RCPsych, 2020). Such strategies require effective collaboration between health and non-health sectors at both governmental and nongovernmental levels, with strong links to the media and the adoption of community-level approaches (RCPsych, 2020; WHO, 2019; WHO, 2014).

## Determinants of Suicide

Biological, psychological, social, cultural, and other factors may interact to bring about suicidal behaviour. Recent meta-analytic research by Favril et al. (2022, 2023) outlined the suicide mortality risk associated with a variety of these factors, thereby summarising prominent risk factors for suicide.

Psychiatric disorders increase the risk of suicide by at least four–fold (Favril et al., 2023). Mood, personality, and psychotic disorders carry the greatest elevated risk, with odds of suicide increasing by at least eight-fold for such disorders (Favril et al., 2023; Favril et al., 2022). Substance use disorders are also associated with increased suicide risk, although to lesser extents (Favril et al., 2023; Favril et al., 2022). Persons who engage in self-harm or with a history of previous suicide attempt are also at a significantly elevated risk for suicide (Favril et al., 2023; Favril et al., 2022). Risk factors tied to the family domain include family history of mental disorder, attempted suicide, and death by suicide (particularly parental) (Favril et al., 2022).

Suicide risk is typically increased two-fold for chronic or terminal physical illnesses, such as cancer, chronic obstructive pulmonary disease, and epilepsy (Favril et al., 2023; Favril et al., 2022). Adverse life events such as relationship conflict, family-related conflict, legal problems, and abuse carry a significant risk for suicide mortality (Favril et al., 2022). Adverse life events occurring within one month prior to suicide death may increase the risk of suicide by 10 times (Favril et al., 2022).

In terms of sociodemographic factors, social isolation (Favril et al., 2022) and unemployment (Favril et al., 2023; Favril et al., 2022) are the strongest risk factors for suicide. Mood disorders and suicidality have been strongly linked to loneliness (McClelland et al., 2020; Beutel et al., 2017), with research suggesting that lonely individuals are more likely to have reduced positive emotions (Preece et al., 2021; Victor & Yang, 2012) as well as lower life satisfaction and less resilience (Zebhauser et al., 2014). The latter characteristics are found to be more common in males than females. Additionally, low educational level and low socioeconomic status are also associated with at least a two-fold increase in risk of suicide mortality (Favril et al., 2023; Favril et al., 2022). Risk of suicide mortality is also increased, but to a lesser extent, for other factors such as committing a criminal offence, state care in childhood, and access to firearms (Favril et al., 2023).

Several studies have demonstrated a significant association between substance use disorders and suicide risk (Borges et al., 2017; Poorolajal et al., 2016; Darvishi et al., 2015; Wilcox et al., 2004). The meta-analysis by Poorolajal et al. (2016) demonstrated increased odds of suicidal ideation, suicide attempts and suicide death for persons with substance use disorders, as compared to healthy counterparts. Additionally, research has shown that acute alcohol use when a person is experiencing suicidal ideation increases the risk of suicide attempts (Borges et al., 2017). Furthermore, the cooccurrence of substance use disorders and mental health disorders exacerbates the risk of suicidal behaviour (Wilcox et al., 2004). These studies collectively underscore the complex interplay between substance abuse and suicide, emphasizing the importance of addressing both issues in preventive and intervention efforts.

Social determinants, which were initially introduced by the WHO Commission on Social Determinants of Health (CSDH) (Solar & Irwin 2010), exhibit an effect on suicidal and self-harming behaviour. Social determinants involve macroeconomic policies (i.e. policies that are concerned with society's overall economy, such as taxation policies), public policies (i.e. policies that relate to broad societal issues, such as healthcare), social policies (i.e. policies concerned with addressing disadvantage, such as social welfare and housing), legislative and/or regulatory frameworks, cultural and societal values, health system capacity/responsiveness and healthcare coverage, and social cohesion and capital (i.e. the extent to which members of society support each other and share a common purpose). Such determinants are cultivated by societal governance, i.e. the structures, processes, and principles that influence the societal decision-making process (Pirkis et al., 2023). Economic recession or taxation policies that widen inequalities exacerbate suicide risk, whereas inflation-control measures or active labour market policies mitigate suicide risk. Strong public and social policies that address the social determinants of mental health have the potential to offset individual risk factors which may be immutable. An important bidirectional interaction therefore exists between the aforementioned individual risk factors and social determinants, which cannot be ignored in the context of suicide prevention strategies (Pirkis et al., 2023).

## Local Determinants of Suicide

It is acknowledged that there is a need of suicidology research in the Maltese Islands. Future research in this field is highly warranted and must be placed as a top priority on the local agenda. Research is imperative to inform future policymaking targeting local mental healthcare and social needs.

One study reviewing locally available evidence on the social determinants of health confirmed an inverse relationship between life-expectancy and chronic health conditions, as well as an inverse relationship between lifestyle behaviours and socioeconomic status (Grima et al., 2018).

Participants in the European Health Information Survey (EHIS) from the Maltese population were screened for the prevalence of symptoms of chronic anxiety and chronic depression within their lifetime and in the previous 12 months. Table 1 summarises figures for chronic anxiety and depression for the surveys carried out in 2014/5 and 2019/20, respectively (England et al., 2022; Gauci et al., 2018).

The social wound of loneliness has garnered increasing attention from local scholars due to its significant impact on mental and physical health. A nationally representative study of the Maltese population aged 11 and above demonstrated that 43.3% of individuals residing in the Maltese Islands experienced some degree of loneliness (Clark et al., 2019). Of these, 41.3% were moderately lonely, 1.7% were severely lonely, and 0.5% were very severely lonely. The study conducted by the Faculty for Social Wellbeing within the University of Malta highlighted several factors associated with loneliness among individuals residing in Malta, including low subjective wellbeing, poor self-rated coping abilities, poor self-rated general health, living alone, marital separation or divorce, widowhood, disability, low education level, unemployment or retirement, financial insecurity, and residing in a mortgaged dwelling (Clark et al., 2019).

The same study was followed up in July 2022, revealing a concerning increase in the prevalence of loneliness among the Maltese population, rising from 43.5% in 2019 to 54.6% in 2022, affecting 198,198 individuals (Azzopardi, 2022). Addressing loneliness requires coordinated efforts from national and local government bodies, non-governmental organisations, and the academic community. Enhanced collaboration among these stakeholders is essential to effectively combat loneliness and enhance social connectedness in Maltese society.

The association between alcohol and substance misuse, and increased suicide risk has been previously highlighted. In the EHIS 2019 Malta data, participants were queried about their alcohol consumption habits over the previous year. Notably, approximately 32% stated they abstained from alcohol entirely in the past year or throughout their lives. For those who did consume alcohol, 22% reported drinking one to two days a week, while 8% indicated daily consumption. When considering binge drinking, defined as consuming six or more drinks on a single occasion, among those who consumed alcohol in the previous 12 months; 46% reported binge drinking less than once a month or not at all, 9% reported risky alcohol intake once a month whilst 31% reported never engaging in binge drinking in their lifetime. The study also revealed that only 1% admitted to engaging in risky alcohol consumption daily or nearly every day.

The European School Survey Project on Alcohol and Other Drugs (ESPAD) is a collaborative effort among European countries to collect data on substance use among students aged 15 to 16 years. The methodology involves a standardised questionnaire administered to a representative sample of students in each participating country. The survey covers various aspects of substance use, including alcohol, tobacco, and illicit drugs, as well as associated factors such as attitudes, perceptions, and behaviours related to substance use.

Table 1

**EHIS data for self-reported lifetime and 12-month prevalence of chronic depression and anxiety. (Gauci et al., 2018; England et al., 2022)**

| | Chronic Anxiety | | Chronic Depression | |
|---|---|---|---|---|
| | **2019** | **2014** | **2019** | **2014** |
| **Lifetime Prevalence** | 5.0% | 7.9% | 4.0% | 6.8% |
| **12-month Prevalence** | 4.4% | 6.2% | 3.5% | 5.3% |

The 2019 ESPAD data for Malta reveals concerning trends in substance use among students aged 15 to 16 years (ESPAD, 2019). Approximately 11.5% of students reported using cannabis in their lifetime, with 4.7% indicating use within the last month. Additionally, 1.1% of students reported lifetime use of ecstasy, 1.9% reported lifetime use of cocaine, and 0.8% reported lifetime use of heroin. Alarmingly, a significant proportion of students reported alcohol use, with 73.1% indicating use within the last year and 48.4% within the last month. Moreover, 40.3% of students reported engaging in heavy episodic drinking within the last month, while 12.1% reported experiencing alcohol intoxication during the same period. These findings underscore the need for targeted prevention and intervention strategies to address substance use among adolescents in Malta, with a particular focus on alcohol and cannabis use, as well as the associated risks of heavy episodic drinking and alcohol intoxication.

By recognising and addressing the role of alcohol and drug use in suicidal tendencies, interventions can be tailored to provide comprehensive support and treatment for individuals at risk. Moreover, integrating substance abuse prevention and treatment measures into broader suicide prevention initiatives can enhance their effectiveness and promote holistic wellbeing within communities (Harkavy-Friedman & Oquendo, 2006; Lynskey et al., 2003).

In addition to addressing alcohol and drug use as part of a suicide prevention strategy, it is imperative to consider the broader factors impacting wellbeing, as highlighted by recent reports on happiness and the wellbeing of children and young people in Malta. The World Happiness Report (Helliwell et al., 2024) revealed that individuals under 30 in Malta are the least happy in the European Union. Malta ranked 57th globally out of 143 countries, earning a score of 6.45 on a scale from 1 to 10. This represented a decrease of nearly 0.4 points compared to the period from 2006 to 2010.

Additionally, the recent release of the report on Wellbeing of Children and Young People in Malta (Cefai et al., 2024) provided further insights. The primary objective of this study was to identify the wellbeing experiences and requirements of children and young individuals residing in Malta, aiming to formulate policy measures that could improve their welfare. It delved into various aspects of children's subjective wellbeing, examining how they differed based on age, gender, nationality/language, disability, and socioeconomic status. Embracing a children's rights approach, the study regarded children as active participants capable of expressing their own perspectives and therefore entitled to participate in the research. Data collection involved the use of three distinct questionnaires tailored for 7- to 8-year-olds, 8- to 11-year-olds, and 11- to 15-year-olds, respectively, with a total of 364 children and young individuals completing the surveys. Among 7- to 8-year-olds, 17.3% experienced bullying and reported being physically assaulted twice or more in the previous month, 21.7% were subjected to derogatory remarks, and 23.1% faced exclusion by their peers. According to the report, although 11- to 15-year-olds generally reported a high level of happiness in their lives, the actual situation revealed by the data was less optimistic. Furthermore, a quarter of 11- to 15-year-olds encountered fights at school on most days, with an additional 11% experiencing this daily. Moreover, 9% of adolescents admitted to frequently resorting to self-harm as a coping mechanism.

Understanding the various dimensions of subjective wellbeing and addressing the challenges faced by different age groups can contribute significantly to creating a more supportive and inclusive environment for the youth in Malta.

# Local Statistics on Suicide

## Standardised Mortality Rate due to Intentional Self-harm

The Standardised Mortality Rate (SMR) due to intentional self-harm in Malta compares favourably with the European Union (EU) average from 27 countries, with rates in Malta being consistently lower than the EU – 27 average (Directorate for Health Information & Research [DHIR], 2024; Eurostat, 2023) (Fig. 1 and Table 2). The SMR is decreasing in both the EU and in Malta, with the EU – 27 average decreasing at a faster rate. Whilst the number of deaths by suicide in Malta is small and favourable, further efforts to prevent suicide deaths are still necessary. In 2023, the SMR in Malta stood at 4.97 deaths per 100,000 population (DHIR, 2024; Eurostat, 2023).

The SMR in Malta is invariably higher for males than females, and this is consistent with other European Union countries (DHIR, 2023; Eurostat, 2023). Table 2 depicts the suicide mortality rate by year and sex for Malta, in comparison with the EU – 27 average.

It is difficult to comment about local trends, given the relatively small number of suicide deaths and considering that Malta lacks a formal suicide mortality register, which poses a challenge in terms of accurate reporting of suicide deaths. However, there seems to be a peak in the Standardised Mortality Rate per 100,000 population during 2014, with a gradual decrease ever since.

The number of deaths from suicide in residents and non-residents by sex is shown in Table 3. This is the only information that is categorised by residents and non-residents.

The latest suicide mortality data for Malta (2023) shows that the highest rate of suicide was recorded in males in the 45-64 age-group (10.31), followed by males aged between 0 and 44 years (8.49) (DHIR, 2024).

The age-sex standardised SMR for individuals with mental disorders who have been discharged from a mental health facility is favourable when compared to the Organisation for Economic Co-operation and Development (OECD) average from 14 countries, with the national SMR in 2020 standing at 0.07/10,000 within 30 days of discharge (OECD – 14 12.4/10,000) and 0.29 within one year of discharge (OECD – 14 35.5/10,000) (OECD, 2021).

Figure 1

**Trends in Standardised Mortality Rate per 100,000 population in Malta vs EU average by year, due to Intentional Self-harm (DHIR 2024; Eurostat 2023).**

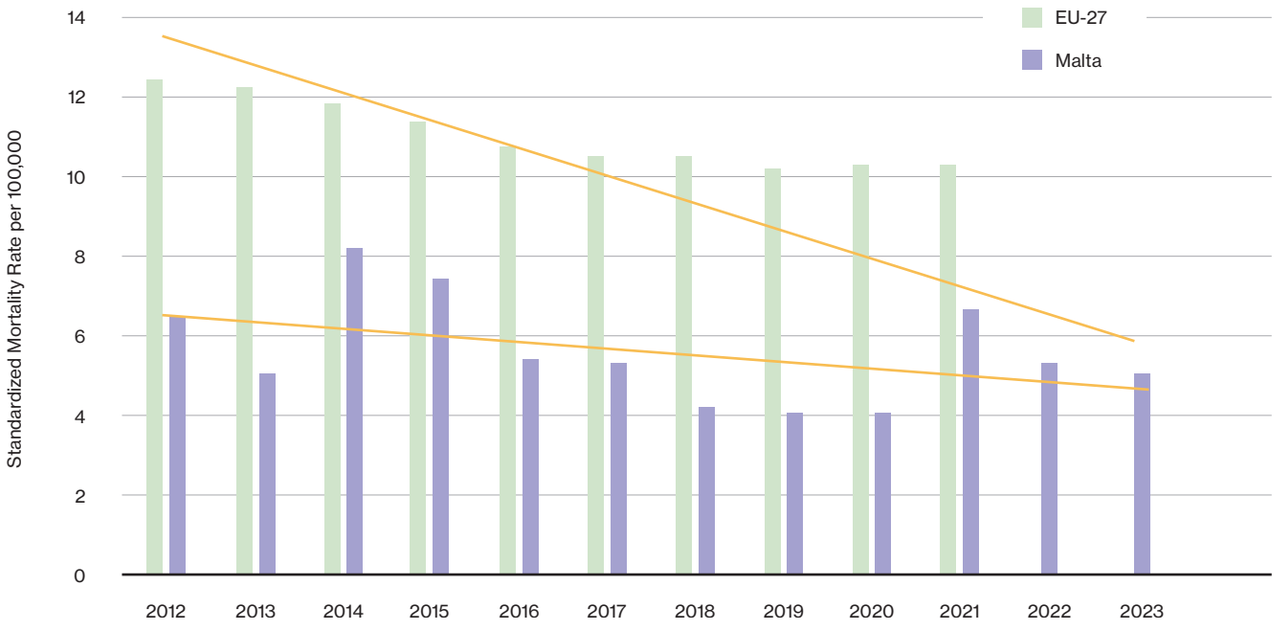


Table 2

**Standardised mortality rate in Malta vs EU average, per 100,000 by year and sex due to Intentional Self-harm (DHIR 2024; Eurostat 2023).**

| Total | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 | 2020 | 2021 | 2022 | 2023 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **EU-27** | 12.3 | 20.2 | 19.5 | 18.7 | 17.7 | 17.2 | 17.2 | 16.7 | 16.8 | 16.7 | | |
| | 8 | 8 | 2 | 5 | 6 | 1 | | | 5 | 5 | | |
| **Malta** | 6.4 | 9.63 | 16.0 | 11.4 | 8.92 | 8.55 | 7.33 | 7.2 | 5.06 | 9.09 | 9.15 | 8.40 |
| | | | | | | | | | | | | |
| Males | | | | | | | | | | | | |
| **EU-27** | 20.69 | 20.28 | 19.52 | 18.75 | 17.76 | 17.21 | 17.2 | 16.76 | 16.86 | 16.75 | | |
| **Malta** | 11.13 | 9.63 | 16.01 | 11.43 | 8.92 | 8.55 | 7.33 | 7.2 | 5.06 | 9.09 | 9.15 | 8.40 |
| Females | | | | | | | | | | | | |
| **EU-27** | 5.22 | 5.3 | 5.15 | 5.03 | 4.66 | 4.65 | 4.67 | 4.41 | 4.48 | 4.55 | | |
| **Malta** | 2.87 | 0.4 | 2.36 | 3.2 | 1.69 | 1.97 | 0.85 | 0.38 | 2.6 | 3.88 | 1.22 | 1.15 |

Figure 2

**Trends in the Standardised Mortality Rate per 100,000 population in Malta, due to Intentional Self-harm by year and sex (DHIR, 2024).**

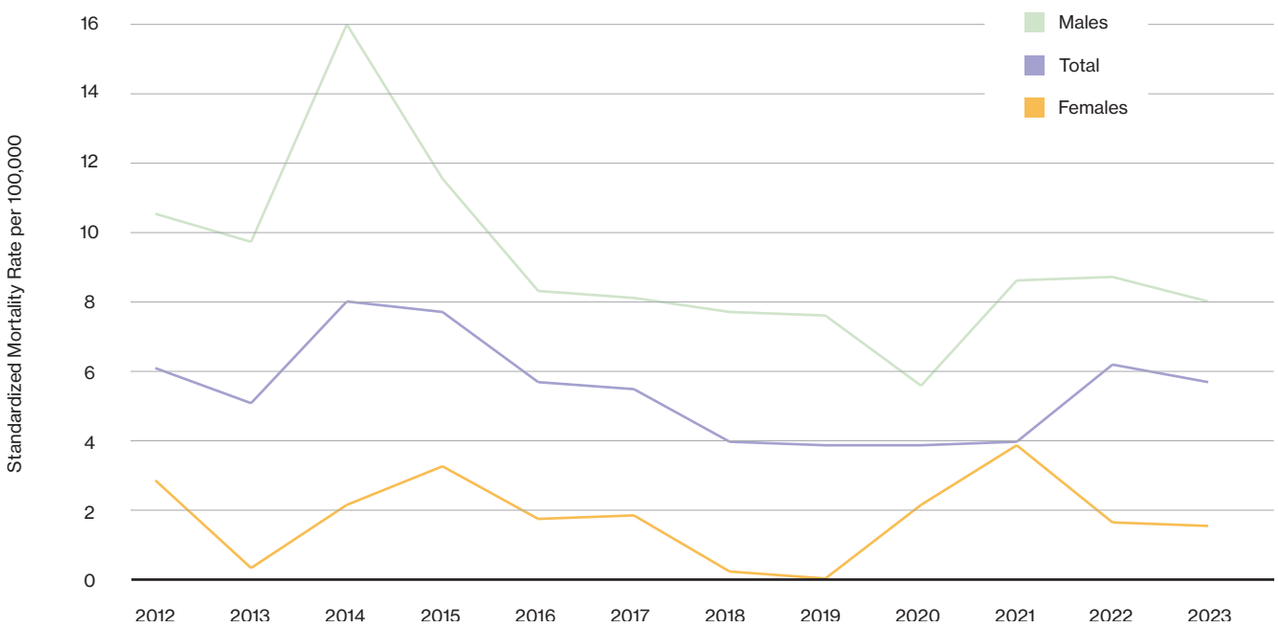


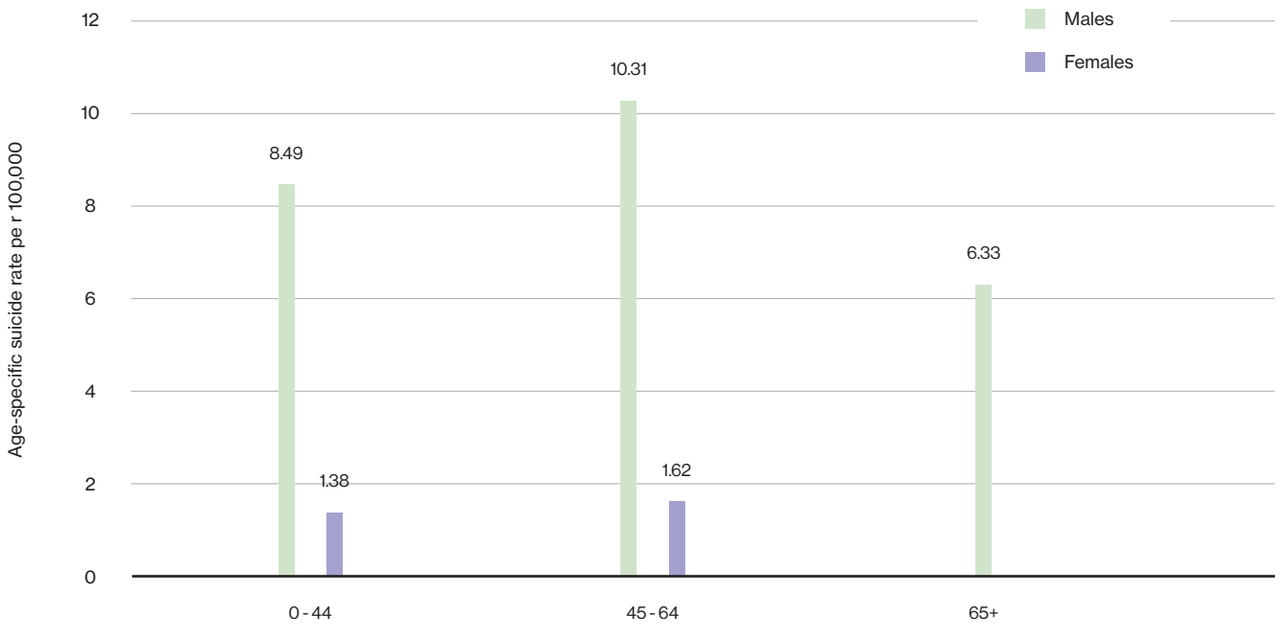
Table 3

**Number of deaths in residents and non-residents by sex, due to suicide in Malta (DHIR, 2024).**

| Year | Residents | | | Year | Non-Residents | | |
|---|---|---|---|---|---|---|---|
| | M | F | Total | | M | F | Total |
| **2012** | 19 | 6 | 25 | **2012** | 2 | 2 | 4 |
| **2013** | 21 | 1 | 22 | **2013** | 5 | 0 | 5 |
| **2014** | 27 | 5 | 32 | **2014** | 4 | 0 | 4 |
| **2015** | 27 | 7 | 34 | **2015** | 4 | 1 | 5 |
| **2016** | 19 | 5 | 24 | **2016** | 2 | 1 | 3 |
| **2017** | 20 | 5 | 25 | **2017** | 1 | 0 | 1 |
| **2018** | 21 | 2 | 23 | **2018** | 1 | 2 | 3 |
| **2019** | 20 | 1 | 21 | **2019** | 2 | 0 | 2 |
| **2020** | 14 | 8 | 22 | **2020** | 0 | 0 | 0 |
| **2021** | 25 | 10 | 35 | **2021** | 2 | 0 | 2 |
| **2022** | 23 | 4 | 27 | **2022** | 2 | 1 | 3 |
| **2023** | 25 | 3 | 28 | **2023** | 0 | 0 | 0 |

Figure 3

**Age-specific suicide rate per 100,000 individuals in 2023, by age group and sex (DHIR, 2024)**



## Risk Factors for Suicidal Behaviour

Data on the number of hospitalisation due to self-harm (Table 4) and data on the most common methods of self-harm (Table 5) has been captured from the National Hospitals Information System (NHIS) and coded using the International Statistical Classification of Diseases and Related Health Problems 10th Revision (ICD -10) system. The NHIS collates data from all hospital discharges in Malta and Gozo, including Mater Dei Hospital (MDH), Mount Carmel Hospital (MCH), and Gozo General Hospital (GGH). For MDH and MCH, discharge data primarily originates from the Electronic Case Summaries (ECS), whilst discharge data is directly received from GGH for discharges from Gozo.

A retrospective longitudinal analysis of local mental health admissions by Warwicker et al., (2023) examined admission data across pre-pandemic, pandemic, and post-pandemic periods from diverse services, with a particular focus on the impact of the COVID-19 pandemic on the instances of suicidal behaviour. The results indicated notable increases in suicidal ideation, suicidal self-injury, and Non-Suicidal Self-Injury (NSSI) between 2019 and 2021. Detailed examination of the data shows a substantial rise in self-harm incidents, particularly among adolescents and young adults (Warwicker et al., 2023).

A 5-year retrospective audit of child and adolescent self-harming behaviour by Grech & Axiak (2016) showed that approximately 38% of all minors who were admitted to Mount Carmel Hospital had harmed themselves prior to admission. The results suggested that male and single-parent family structure were significant risk factors for self-harm in Maltese children and adolescents.

A brief analysis of data gathered by the Crisis Resolution Home Treatment (CRHT) team demonstrates that between 2022 and 2023, 130 persons were referred to CRHT following a suicide attempt. The attempts involved medication overdose, hanging, self-lacerations, and self-stabbing. Attempts were most common among females (n=75, 57.7%), persons in gainful employment (n=98, 75.4%), and with a mean age of 35.8 years. Marital status did not impact the results. Around a third (36.2%) of all suicide attempts were performed by non-Maltese nationals. Relationship problems, including breakup and marital/relationship disharmony, were the leading precipitating factors (n=60, 46.2%), followed by family problems (n=19, 14.6%). Persons who attempted suicide and who were subsequently treated by CRHT were most commonly diagnosed with Adjustment Disorder and/or Acute Stress Reaction (n=47, 36.2%), Depression (n=21, 16.2%) and Borderline Personality Disorder (n=17, 13.1%). Two local studies investigating suicide deaths in the Maltese Islands were conducted by Renaud (2019) and Camilleri (2021). Collectively, both studies investigated the prevalence and characteristics of individuals who died by suicide in the Maltese Islands between 1995 and 2018. The study by Renaud (2019) identified a heightened suicide risk for individuals who were male, aged 30 to 49 years, had single or separated status, and were unemployed or pensioners. The study by Camilleri (2021) also identified a heightened suicide risk for individuals who were male but noted an increased suicide risk in a different age bracket, i.e. individuals aged 46 to 60 years. The collective sociodemographic risk factors are highlighted in Figure 4.

In the study by Camilleri (2021), data was retrieved from police reports of all 359 recorded suicide deaths between 2003 and 2017. In this study, 19.2% (n=69) of all suicide decedents had had contact with National Mental Health Services. Mental health issues were only annotated by the police in 33.1% (n=119) of deaths by suicide. Specific psychiatric diagnoses were recorded in only 13.9% (n=50) of all cases, with depression being the most common reported diagnosis.

In contrast, the study by Renaud (2019) retrieved data from the medical records of 635 suicide decedents who died between 1995 and 2018. More than half (57.0%, n=211) of suicide decedents investigated by Renaud (2019) had had contact with National Mental Health Services (6.3% >1 year; 93.7% <1 year), with the majority of service users being females (74.0%).

Camilleri (2021) and Renaud (2019) both note two seasonal peaks in the national suicide rate, reflecting increased suicide deaths in spring and summer. The rate of suicide in Malta is highest in the Northern Harbour district when compared to other districts (Camilleri, 2021). The most common locations for suicide are noted to be the home (Camilleri, 2021; Renaud, 2019) and garages (Camilleri, 2021). For individuals choosing to jump from a height, the bastions are the preferred location for suicide, particularly in the Southern Harbour district where most of the bastions are located (Camilleri, 2021). Individuals from the Northern District who die by jumping from a height tend to do so from the Mosta bridge, which is located in the same district (Camilleri, 2021). In addition to the locations mentioned by Camilleri (2021), Renaud (2019) also notes a significant number of suicides occurring at Dingli Cliffs and the Lascaris Ditch in Valletta.

Table 4

**Number of hospitalisations due to self-harm in 2020, by age group and sex (NHIS, 2023).**

| | Age Group (years) | | | | | | |
|---|---|---|---|---|---|---|---|
| | **0-19** | **20-39** | **40-59** | **60-79** | **≥80** | **Unspecified** | **Total** |
| **Female** | 25 | 57 | 50 | 14 | 0 | 0 | 146 |
| **Male** | 46 | 70 | 34 | 12 | 6 | 2 | 170 |
| **Total** | 71 | 127 | 84 | 26 | 6 | 2 | 316 |

Table 5

**Most common methods of self-harm for year 2020, with or without suicidal intent, by age group and sex.**

| | Age Group (years) | | | | | |
|---|---|---|---|---|---|---|
| | **0-19** | **20-39** | **40-59** | **60-79** | **≥80** | |
| **Female** | Poisoning (Y10) | Poisoning (Y10) | Intentional self-poisoning (X61) | Intentional self-poisoning (X61) | Intentional self-poisoning (X64) | #1 |
| | Intentional self-poisoning (X61) | Intentional self-poisoning (X61) | Poisoning (Y10) | Intentional self-poisoning (X60) | Unspecified means (X83) | #2 |
| | Unspecified means (X83) | Unspecified means (X83) | Unspecified means (X83) | Poisoning (Y10) | Intentional self-poisoning (X61) | #3 |
| **Males** | Intentional self-poisoning (X69) | Unspecified means (X83) | Intentional self-poisoning (X61) | Intentional self-poisoning (X61) | Intentional self-poisoning (X64) | #1 |
| | Hanging (X70) | Intentional self-poisoning (X61) | Intentional self-poisoning (X64) | Unspecified means (X83) | Unspecified means (X83) | #2 |
| | Unspecified means (X83) | Sharp object (X70) | Hanging (X70) | Hanging (X70) | Intentional self-poisoning (X61) | #3 |

Hanging is the most recorded suicide method; however, a difference prevails as jumping from heights is noted to be the commonest method of suicide for females (DHIR, 2023; Camilleri, 2021; Renaud, 2019). Figures from the National Mortality Register (2017-2021) show that the commonest means of suicide are hanging (n=81), jumping from a height (n=20), overdosing (n=9), and firearm discharge (n=6), in decreasing order across all age groups. Renaud (2019) also outlined a relationship between younger age groups and a greater tendency for suicide via self-poisoning by gases, and a relationship between older age groups and suicide via drowning or submersion. The latter study also reported the three most common suicide methods by gender (Figure 5).

Further prospective and longitudinal research that is based on data triangulation is necessary to elicit clear predictors of self-harm and suicide within the local context. This is projected to increase clinician sensitivity and accuracy in terms of suicide risk detection and reduce reporting biases.

Figure 4

**Sociodemographic risk factors for suicide in Malta. Adapted from Camilleri (2021) and Renaud (2019).**

| | |
|---|---|
| Male | Age 30 to 60 Years |
| Single or Separated | Unemployed or Pensioner |

Figure 5

**Most common suicide methods by gender, adapted from Renaud (2019).**

| ♂ | ♀ |
|---|---|
| **01** Hanging, strangulation, or suffocation | **01** Jumping from a height |
| **02** Jumping from a height | **02** Hanging, strangulation, or suffocation |
| **03** Firearm | **03** Self-poisoning with medication |

02

# National Mental Health Services

## The Mental Health System

Malta's strategy entitled 'A Mental Health Strategy for Malta 2020-2030: Building Resilience Transforming Services' was published in July 2019.

**Actions within the strategy are grouped under four thematic clusters.**

### 01

Promoting mental health wellbeing by addressing the wider determinants of health.

### 02

Transforming the framework within which mental health services are delivered.

### 03

Supporting all persons with mental disorders and their families.

### 04

Promoting mental health wellbeing by addressing the wider determinants of health.

The implementation of the mental health strategy has been entrusted to the Senior Management Team of the National Mental Health Services, who will report directly to the Chief Medical Officer on the progress registered.

In the Budgetary estimates for 2024, the Maltese government allocated 69 million euro to the National Mental Health Services, equivalent to 6.8% of the total health budget.

It is observed that male admissions to all mental health facilities in Malta and Gozo significantly exceed female admissions. In the year 2023, the proportion of involuntary admissions to the Mount Carmel Hospital (MCH) (n=1019) to the number of total MCH admissions (n=2590) was 0.39. The proportion of male admissions (n=1686) to the number of total MCH admissions (n=2590) was 0.65. The proportion of involuntary male admissions (n=628) to the number of total involuntary admissions (n=1019) was 0.62. This male to female ratio in admissions to Gozo hospital is roughly the same as that found in Malta (3:2).

In the year 2023, the proportion of involuntary admissions to the Gozo Short Stay Psychiatric Unit (SSPU) (n=57) to the number of total SSPU admissions (n=141) was 0.40. The proportion of male admissions (n=92) to the number of total SSPU admissions (n=141) was 0.65. The proportion of involuntary male admissions (n=35) to the number of total involuntary admissions (n=57) was 0.61. In the year 2023, there were only six admissions to the Long Stay Psychiatric Unit for extended psychiatric care. In total, 147 inpatients were hospitalised at the two psychiatric units within Gozo General Hospital in the year 2023.

In the year 2023, 362 persons were referred to the Crisis Resolution Home Treatment (CRHT) team, and 323 persons received intensive community-based psychiatric care from the CRHT team. The mean age of service users was 35.5 years (SD=13.95) and 53% (n=191) of all service users were male. Persons were mostly referred from the Central and Northern Regions of Malta, with less persons requiring the team's support from the Southern Region. More than one third (36%) of all service users were referred in view of suicidal ideations, whereas 18% were referred following a suicide attempt. The rest of the referrals were received in view of other acute mental distress and/or acute mental disorders. Figure 6 illustrates the distribution of CRHT service users' diagnoses in the year 2023.

Additionally, the staff at the Young People's Unit at Mount Carmel Hospital provided a total of 138 emergency consultations to minors presenting to the Accident and Emergency (A&E) Department within Mater Dei Hospital through Child and Adolescent Psychiatric Emergency Service (CAPES) and provided intensive community-based psychiatric care to 152 minors through Crisis Intervention and Home Treatment (CIHT). In the year 2023, 16 minors required inpatient admission to the Young People's Unit at Mount Carmel Hospital following CAPES intervention, of which 68.8% (n=11) were male. In comparison, 62.5% (n=95) of CIHT service users were female.

Data from the 1579 National Mental Health Helpline reveals that since the helpline's inception in November 2022 until April 2024, 11,919 calls were received. Of these, only 2.9% (n=349) calls were suicide related. Figure 7 shows the total number of calls related to suicide per month. Peaks can be noted in the months of June, July, and August 2023, as well as April 2024. The peaks coincide with seasonal changes, which have been associated with increased suicidality in the literature (Galvão et al., 2018; Christodoulou et al., 2012). It is interesting to note that female callers continually superseded male callers between November 2022 and November 2023, yet this picture has shifted as of December 2023, with male callers calling the helpline more frequently. Collection of more detailed variables can help identify areas of concern or improvement and inform future decision-making processes regarding resource allocation and service enhancements.

According to Eurofound survey data from 2021/22, around 10% of the Maltese population reported unmet healthcare needs during the COVID-19 pandemic, a fifth of which were related to mental healthcare (OECD & European Observatory on Health Systems and Policies, 2023). The percentage of unmet mental healthcare needs was considerably lower outside of the pandemic. The share of people reporting unmet mental healthcare needs due to financial reasons stood at 2.1% in 2014 and 1.6% in 2019 (Rens et al., 2022). It is notable to heed that the adequate detection and fulfilment of the mental healthcare needs of migrant and refugee populations remains a major concern in Malta (Borg et al., 2022), particularly since the number of interpreters and cultural mediators who are embedded within the health system is scarce.

In line with the standards and values set out in the Mental Health Strategy for Malta, the NMHS are endeavouring to shift the locus of care away from institutional psychiatric hospitalisation and towards community mental healthcare. In recent years, there has been ample investment in the development of community-based National Mental Health Services, such as the Crisis Resolution Home Treatment (CRHT) team which offers an alternative to psychiatric hospitalisation, Community Mental Health Teams which offer long-term follow-up and multidisciplinary support for persons with mental health disorders, and nurse-led outreach teams which offer intense support and care for persons with complex mental health needs (Azzopardi-Muscat et al., 2017). Since these services are offered within individuals' community milieu, they help to reduce stigma and enhance patient accessibility (Scerri et al., 2023).

The Mental Health Act (2012) clearly stipulates that persons with a mental disorder have a right to "actively participate in the formulation of the multidisciplinary treatment plan" (MHA CAP 525, pg. 4, part II, par. 3). Research has consistently shown that shared decision-making is in keeping with the fundamentals of the recovery model of care (Chmielowska et al., 2023; Jørgensen & Rendtorff, 2017; Slade, 2017), with an integrative review demonstrating that its practice leads to multiple patient benefits, including but not limited to; diminished symptomology, improved self-esteem, increased satisfaction and improved treatment adherence, and decreased rates of hospitalisation (Alguera-Lara et al., 2017). Hence, it is essential for persons in suicidal crises to be involved in shared decisionmaking, when and if possible, so that they may benefit from positive treatment outcomes and therapeutic collaboration. It is to be noted that persons with lived experience of mental illness have been consulted for the writing of this strategy.

Figure 6
**Distribution of CRHT service users' diagnoses in the year 2023.**

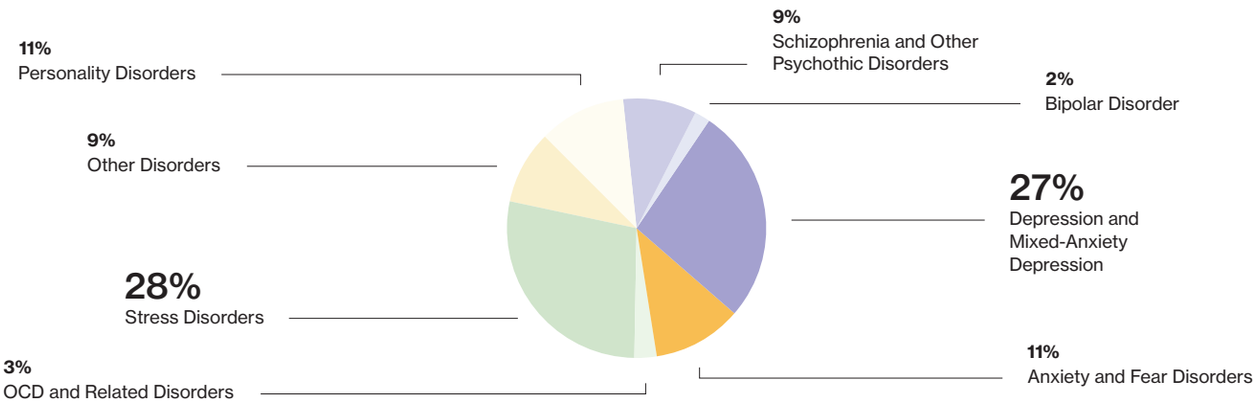
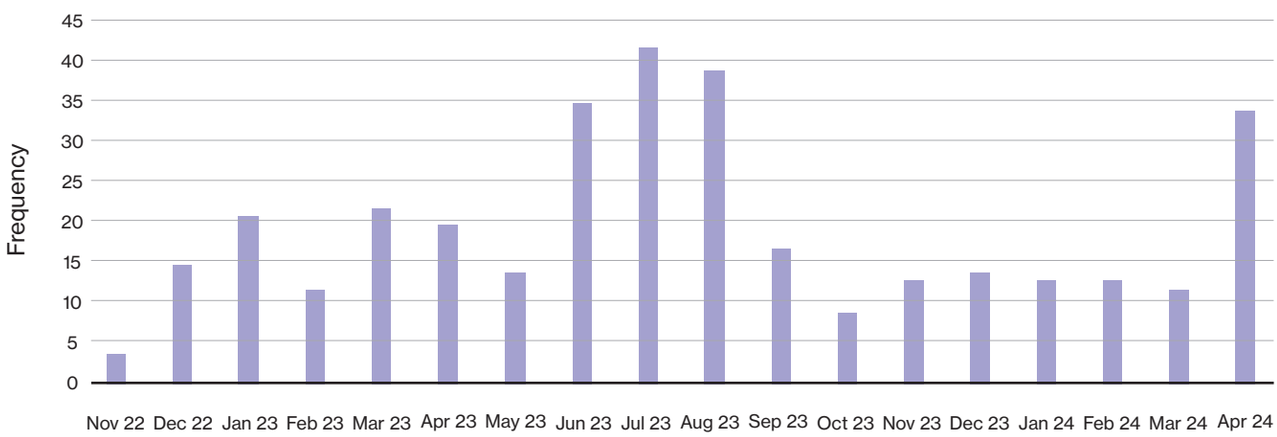



Figure 7
**Distribution of suicide-related calls received by the 1579 National Mental Health Helpline.**



## The National Mental Health Services

The National Mental Health Services (NMHS) are provided by Multi-Disciplinary Teams (MDTs) that assess patients' mental state, provide expert care and treatment tailored to patients' unique needs, and support patients and their relatives in a holistic and person-centred manner. MDTs are typically led by psychiatrists and comprise of psychiatric trainee doctors, psychiatric nurses and/or general nurses with special interest in mental health, psychologists, occupational therapists, social workers, and other allied healthcare professionals. The Mental Health Act stipulates that the persons with a mental disorder have a right to "actively participate in the formulation of the multidisciplinary treatment plan" (MHA CAP 525).

NMHS are provided both within community and hospital settings. With recent advancements in community National Mental Health Services and the subsequent momentum towards non-institutionalised care, the Community Mental Health Teams (CMHTs) have become the mainstay of care. There are currently six Community Mental Health Teams in Malta: two in the Northern Region (Mtarfa & Mosta-Qawra Roaming Team); two in the Central Region (Qormi & Floriana); and two in the Southern Region (Paola & Cospicua). There is also one psychiatric outpatients' clinic within Gozo General Hospital that provides services to the whole population in Gozo. CMHTs operate from clinics which may be found within primary health care centres or as stand-alone clinics within the community setting. The CMHT is a multidisciplinary National Mental Health Service that provides assessment, therapeutic interventions, and evidence-based treatment to adult patients with suspected or diagnosed moderate to severe mental illness. Persons who are referred to their regional CMHT would typically require specialist secondary care input for reasons of complexity, severity, lack of treatment response, or insufficient level of care or specialist knowledge from primary care teams or personal general practitioners. The equivalent of the CMHT for child and adolescent patients with mental health issues and disorders are the Child and Young People's Services (CYPS), which are based at St Luke's Hospital, Msida.

When persons with mental health disorders exhibit psychiatric symptoms which cannot be contained within a community setting and/or exhibit significant risk of harm to self or others, a psychiatric admission within a mental health facility is warranted. The admission may either be on a voluntary basis, or on an involuntary basis as provided in the Mental Health Act (2012). Mount Carmel Hospital is the sole inpatient psychiatric facility in Malta. In Gozo, there are two psychiatric units as part of Gozo General Hospital. The evidence-based care that is provided within an inpatient mental health facility is also of a multi-disciplinary nature with therapeutic interventions being provided by various professionals within the multi-disciplinary team.

## Specialised Services

In addition to the aforementioned services, NMHS also provide multiple specialised services in relation to Substance Use Disorder and/or Dual Diagnosis (inpatient at MCH & community), Old Age Psychiatry (inpatient at MCH, residential care at Saint Vincent De Paule Residence/Karin Grech Hospital [SVPR/KGH] & community), Intellectual Disability (inpatient at MCH, residential care & community), Eating Disorders (inpatient & outpatient at Dar Kenn Għal Saħħtek [DKGS]), Neuropsychiatry (outpatient at MDH), Perinatal Mental Health (inpatient at MDH and outpatient) and Student Wellbeing (University of Malta and the Malta College for Arts and Science [MCAST]). NMHS also offer a Psychiatry Liaison Service within MDH, which provides mental health assessment for patients exhibiting psychiatric symptoms during their medical admission at MDH. The Psychiatric Liaison Service also reviews patients who present to the Accident & Emergency Department within MDH with a mental health crisis. It is notable to heed that there is also collaboration between NMHS and Non-Governmental Voluntary Organisations (NGOs), in the provision of rehabilitative accommodation programmes and supported living accommodations within the community.

A brief outline of all the services offered by NMHS is described in Appendix 2. The referral pathways for each service are delineated according to the unique criteria of each service.

## Crisis and Emergency National Mental Health Services

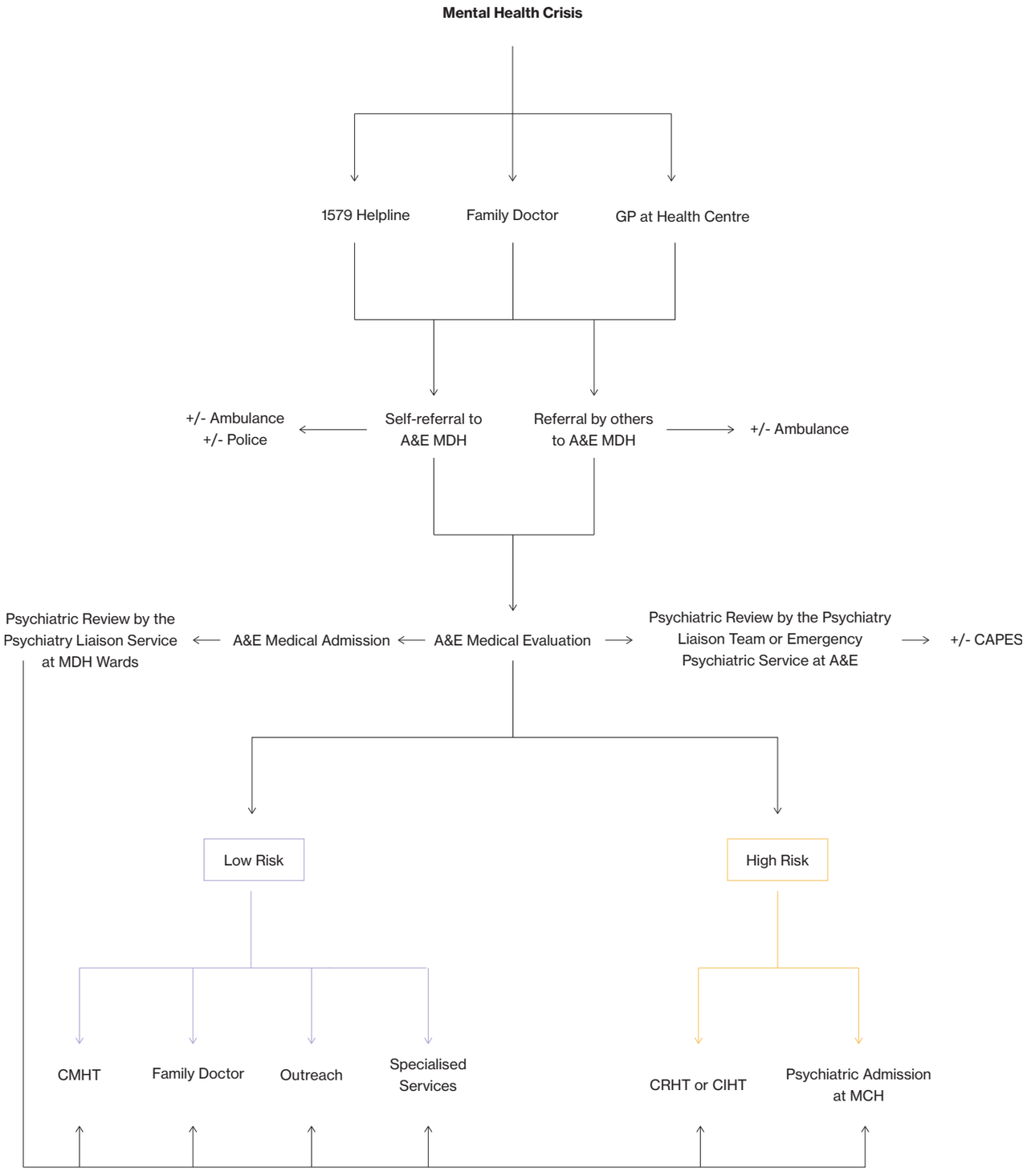
The national NMHS offer a 24/7 Emergency Psychiatric Service (EPS), which is based in the Accident & Emergency (A&E) Department within MDH. Through this service, on-call psychiatrists and/or senior psychiatry trainee doctors, offer acute mental health assessment and treatment to persons who present to the A&E Department in a mental health crisis or with acute mental disorders. The EPS is supported by mental health nurses during daytime hours. The EPS is further supported by the Child & Adolescent Psychiatric Emergency Services (CAPES), which are offered by specialist nurses who conduct assessments for young people aged 3 to 18 years presenting to the A&E Department in a similar manner.

Following emergency psychiatric assessment, the person in a mental health crisis or with an acute mental disorder is referred to the most appropriate service, in accordance with the pathways of care shown in Figure 8. The pathways of care described apply to persons who have never been in contact with National Mental Health Services and who are not supported by any of the aforementioned teams.

The Crisis Resolution Home Treatment (CRHT) team for adults and the Crisis Intervention and Home Treatment (CIHT) team for minors are intensive, community-based services that serve as an alternative to psychiatric hospitalisation when the individual's risk profile is amenable to community psychiatric care. Both services offer timely and compassionate psychiatric care to individuals in a mental health crisis or with an acute mental disorder for a period of 3 to 4 weeks. Following this timeframe, the teams endeavour to facilitate the smooth, professional, and non-traumatic transition to long-term community National Mental Health Services such as the regional Community Mental Health Teams (CMHTs) and the Child and Young People's Services (CYPS). Ultimately, service users are empowered to address their mental health needs and to reinforce their resilience through evidence-based interventions and psychoeducation. Ultimately, service users are encouraged to foster adaptive coping abilities so that they may avoid, or reduce, the severity of future crises and achieve a fulfilling and good-quality life.

Additionally, NMHS operate a 24/7 national telephone helpline through the 4-digit hotline – 1579. The helpline is staffed by psychology professionals who provide free and immediate emotional and psychological support, professional advice, and practical guidance to anyone experiencing mental distress. The helpline also helps persons in a mental health crisis, or their relatives, to navigate through appropriate services so that they may access the most relevant National Mental Health Service.

Figure 8
**Pathways of care for a mental health crisis.**



# 03 Stakeholder Involvement

Implementing the Suicide Prevention Strategy in Malta requires a multifaceted endeavour due to its comprehensive and inclusive nature. This strategy, designed to address suicide across all sectors of society, necessitates sustained cooperation and communication among a diverse array of stakeholders.

This includes government departments, local authorities, educational institutions, nonstatutory and community organisations, service users, NGOs and social partners. Collaborative engagement and participation from these entities are essential for the strategy's success, as they bring diverse perspectives and expertise to the table.

Furthermore, active involvement of key delivery organisations is paramount. These organisations encompass various sectors such as healthcare, education, social services, correctional services, community services, sports, and religious institutions. An Advisory Board made up of stakeholders was established to facilitate the input from these entities in an effort for the strategy to be able to address the specific needs and challenges within each sector. The inclusion of the lived experiences of service users adds a crucial dimension to the strategy's development. Their insights provide valuable perspectives on the realities of suicide and its impact on individuals and communities.

The public consultation process played a pivotal role in shaping the Suicide Prevention Strategy. It provided a platform for individuals and organisations with an interest in mental health to contribute their knowledge and expertise. Over 40 stakeholders, including persons with lived experience, family of persons with lived experience, professionals, and community groups, participated in this process. Their input during the consultations, helped inform the development of the strategy, ensuring that it is grounded in real-world experiences and needs.

The following are some of the themes that emerged from the consultation process that would inform the strategy.

By addressing these priorities in a coordinated manner, Malta can work towards reducing the incidence of suicide and promoting mental wellbeing across the population.

A list of all consulted stakeholders
can be found in Appendix 3.

## Collaboration with Other Stakeholders

- Fostering partnerships across sectors.
- Strengthening collaboration with NGOs.
- Adopting an empathic and compassionate approach in discussions and implementation processes.

## Mental Health Promotion and Prevention

- Acknowledging the impact of an effective and ongoing mental health campaign, with proper referral to emergency numbers and services.
- Promoting mental health awareness.
- Encouraging responsible media reporting.
- Breaking stigma.
- Focusing on awareness and education throughout the lifespan, and normalising discussions related to mental health.

## Investing in National Mental Health Services and Delivery

- Establishing robust leadership and governance structures.
- Tailoring interventions for specific demographic groups.
- Utilising evidence-based research and evaluation findings to inform decision-making.
- Prioritising early intervention and access to clinical services.
- Establishing accurate referral pathways to facilitate access to National Mental Health Services, especially in emergencies and crises situations.
- Acknowledging and minimising the fear and stigma associated with mental health facilities.

## Supporting the Mental Healthcare Workforce

- Addressing burnout and retention of healthcare workers through organisational support and improved employment conditions, with proper induction and supervision.

# 04 Implementation Strategy

**The implementation strategy is underpinned by six pillars that are essential for suicide prevention. Each pillar comprises of strategic goals, from which relevant actions and objectives emanate. An action plan is accessible in Appendix 4.**

**The six major strategic areas are**

**01**

Coordination and Organization

**02**

Support and Treatment

**03**

Restriction of Access to Means

**04**

Awareness and Knowledge

**05**

Prevention and Health Promotion Activities

**06**

Quality Assurance and Expertise

Pillar 01

# Coordination and Organization

## Strategic Goal 1

## Suicide prevention is organisationally embedded and coordinated.

The National Mental Health Services (NMHS), within the Ministry for Health and Active Ageing (MHA), have delineated the first Suicide Prevention Strategy for Malta. The successful implementation of this strategy requires a whole-of-government approach that involves joint activities and cross-boundary collaboration performed by diverse ministries, public agencies and voluntary organisations to provide a comprehensive plan of action for National Suicide Prevention.

Responsibility for the coordination and implementation of the National Suicide Prevention Strategy will chiefly be held by NMHS. The Senior Management Team within NMHS will report on the progress registered to the Chief Medical Officer. A committee made up of a wide range of stakeholders emanating from various ministries, entities and Non-Governmental Organisations (NGOs) and individuals bereaved and/or affected by suicide, shall oversee the implementation of the planned actions as outlined in this Chapter.

## Implemented Actions

### 01

Setting up of an Advisory Committee with stakeholders from the Ministry for Health and Active Ageing, inter-ministerial stakeholders, extra-ministerial stakeholders, and NGOs in the field of mental and social care.

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### 02

Appointing a staff member from the Crisis Resolution Home Treatment (CRHT) Team to the Advisory Committee to garner insights about persons in mental health and suicidal crises.

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### 03

Conducting a wide consultation process with stakeholders and policy makers to inform the required strategic actions.

## Planned Actions

### 01

Set up a committee within the Ministry for Health and Active Ageing to steer and coordinate the actions of the strategy.

### 02

Set up a committee composed of inter-ministerial and extra-ministerial stakeholders, NGOs and other entities to facilitate the actions of the strategy.

### 03

Conduct an evaluation of the strategy, including actions performed and Key Performance Indicators (KPIs) achieved, midway through the strategy's stipulated 5-year period.

## Key Performance Indicators

### 01

Strategy review.

### 02

Number of meetings held by the Strategy Committee.

Pillar 02

# Support and Treatment

## Strategic Goal 2A
## Gatekeepers are competent in dealing with people at risk of suicide and risk groups.

Detection and/or screening for suicide risk and mental health support are provided through identified gatekeepers, so that persons in crisis may be assisted in a wide range of environments.

Gatekeepers are individuals and professional groups who are at increased likelihood of encountering people in suicidal crises due to the nature of their occupation. Gatekeepers may include health and social care professionals, police officers, and teachers, amongst others. Gatekeepers should be in a position to intervene appropriately by identifying individuals who show warning signs of suicide risk and to refer such individuals to appropriate services.

Gatekeeper training aims to increase participants' knowledge and understanding of suicidal behaviour and to increase participants' capacity for responding effectively. The training that is provided needs to be adapted to address the particular needs of its recipients.

### Implemented Actions

**01**

A qualified mental health professional has delivered the Assessing and Management of Suicide Risk (AMSR) training to all NMHS community mental health professionals.

## Planned Actions

### 01

A qualified mental health professional will provide training on suicide risk assessment and management to all inpatient NMHS mental health professionals.

### 02

Implement a training needs analysis for health care professionals as gatekeepers.

### 03

Provide training resources and learning opportunities for health professionals.

### 04

Identify key gatekeepers who would benefit from training on suicide risk assessment and management.

### 05

Support gatekeepers in establishing protocols at the workplace/schools to minimise suicide risk and to provide timely support for at-risk persons and other persons who may be affected.

### 06

Improve collaboration between NMHS and the police force, since police officers are often the first persons on the scene, particularly in high-risk situations. It should be ensured that police officers are equipped with the right skillset (in terms of communication, physical intervention, and de-escalation) for engaging with, supporting, and transferring persons in crisis in a safe, respectful, and dignified manner and in their support of the person's relatives.

### 07

Improve collaboration between NMHS and primary care doctors including GPs and GP trainees through improved communication channels and the provision of training by specialists in psychiatry.

## Key Performance Indicators

### 01

Number of gatekeepers successfully completing training.

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### 02

Feedback from post training satisfaction surveys.

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### 03

Number of meetings with gatekeepers.

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### 04

Number of protocols that are established.

## Strategic Goal 2B
## Sufficient psychosocial support and care structures are provided for persons in crisis.

Appropriate and timely mental healthcare services are essential prerequisites for successful suicide prevention. The WHO (2018) advocates for the provision of easily accessible assistance for persons experiencing a mental health crisis and for persons affected by suicidal behaviours, through the provision of 24-hour emergency psychiatric services.

**Emergency and Stabilisation**

The 1579 National Mental Health helpline was launched in November 2022 with the aim of providing free and immediate emotional and psychological support, professional advice, and practical guidance to anyone experiencing mental distress. The helpline operates on a 24-hour basis and is provided by trained psychology professionals. The helpline may be the first point of call for persons or caregivers of persons experiencing a mental health crisis. By contacting the helpline, such individuals may be promptly assisted and directed to the most appropriate National Mental Health Service.

Emergency services within the area of mental health are available on a 24-hour basis and are provided from the A&E Department at Mater Dei Hospital and Gozo General Hospital. The Emergency Psychiatric Service (EPS) at Mater Dei Hospital provides rapid assessment and treatment for persons in crisis. The Child and Adolescent Emergency Psychiatric Service (CAPES) operates from the A&E v at MDH and supports children and adolescents in crisis.

Following emergency assessment by the EPS, persons in crisis may be further supported by the Crisis Resolution Home Treatment (CRHT) team for adults and the Crisis Intervention and Home Treatment (CIHT) team for minors. Both services provide intensive, community-based psychiatric care to individuals experiencing a mental health crisis (which may involve suicidality) as an alternative to psychiatric hospitalisation. The crisis teams follow the client for a period of 3-4 weeks after which they may be sign-posted to other services.

## Implemented Actions

### 01

Establishing the Crisis Resolution Home Treatment (CRHT) team in December 2021.

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### 02

Establishing the 24/7 National Mental Health Helpline in November 2022.

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### 03

Providing universal psychiatric follow-up within the community to persons who have attempted suicide and to persons who are discharged from mental health facilities.

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### 04

The Emergency Psychiatric Service (EPS) and the Psychiatry Liaison Service (PLS) support the Accident and Emergency (A&E) Departments in assessing, treating and managing persons with acute mental illness or a mental health crisis so that patients may receive specialist and holistic care.

## Planned Actions

### 01

Provide ongoing training to mental health professionals working at all Emergency and Stabilisation services as outlined above, to ensure that they have sufficient knowledge to support persons in crisis and mitigate risk in the most effective manner possible.

### 02

Train A&E pre-hospital professionals in verbal de-escalation, acute mental health assessment and suicide risk assessment to improve pre-hospital care.

### 03

The building of an acute mental health centre within Mater Dei Hospital to provide acute mental health care in a destigmatised, dignified, and therapeutic environment.

### 04

Prioritise patients' right to privacy and dignity during psychiatric assessment at the A&E Department at Mater Dei Hospital by securing a private area for mental health assessment.

### 05

Encourage the uptake of organisational psychological support for A&E and NMHS personnel to safeguard employee wellbeing.

## 06

Further develop the Emergency Psychiatric Service (EPS) and ensure that it is well-resourced to provide timely psychiatric assessment and care to persons who present to the A&E Department with a mental health crisis, particularly persons who are in a suicidal crisis.

## 07

Ensure that the CRHT team is well-resourced with an adequate number of multi-disciplinary professionals and invest in ongoing training for staff members.

## 08

Extend the CRHT service to a 24-hour/7-day basis.

## 09

To introduce newer generation antidepressant medications with more favourable side-effect profiles (such as Sertraline and Escitalopram) to be placed on the governmental formulary since antidepressant treatment has been proven to reduce the risk of suicide and has not been associated with an increased risk of suicide on initiation (RCPsych, 2020).

## Key Performance Indicators

### 01

Number of interventions by 1579 personnel.

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### 02

Number of interventions by CRHT and CIHT.

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### 03

Hospitalisation rate of clients seen by the CRHT team.

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### 04

Number of training sessions given to mental health professionals working in Emergency and Stabilisation services.

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### 05

Number of training sessions provided to pre-hospital care providers.

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### 06

New antidepressants introduced on the governmental formulary.

## Strategic Goal 3
## Sufficient psychosocial support and care structures are provided to highrisk groups.

The WHO (2023a) highlights the following high-risk groups who are at increased risk of suicide:

- persons with mental disorders (in particular, depression and substance use disorders),
- persons with a previous suicide attempt,
- persons who experience a crisis and who subsequently face a breakdown in the ability to deal with life stresses, such as financial problems, relationship breakup, or chronic pain and illness,
- persons experiencing conflict, disaster, violence, abuse, or loss, and a sense of isolation,
- vulnerable groups who experience discrimination, such as refugees and migrants; indigenous peoples; Lesbian, Gay, Bisexual, Transgender, Intersex and Queer (LGBTIQ+) persons; and prisoners.

Individuals with chronic disorders, terminal illness and chronic pain are particularly vulnerable to suicide risk (Kwon & Lee, 2023; Nafilyan et al., 2022; Calati et al., 2015). Professionals providing care for these individuals need to be highly skilled in breaking unpleasant news so that they may do so in the most compassionate and sensible manner possible. They must also ensure that sufficient psychosocial support is provided to such persons since these morbidities may cause a deterioration in people's quality of life (Siboni et al., 2019; Strine et al., 2008).

Furthermore, research has demonstrated that risk of suicide increases when patients are transitioning between inpatient psychiatric care to community care (Chung et al., 2019; Chung et al., 2017). This was reflected during a focus group with local service users, who deemed this transition period as "a critical point" because of the heightened sense of vulnerability and lack of support felt during this point in care.

In addition to the above groups, persons at risk of suicide locally (as mentioned in Chapter 2) include (i) males, (ii) persons within the 30 to 60 age brackets, (iii) persons who are single or separated, and (iv) persons who are unemployed or pensioners. It is to be ensured that actions in the strategy particularly target high-risk groups.

The development of suicide prevention intervention for high-risk groups is critical to minimise the suicide rate. On a global level, it is worrisome that many at-risk persons are not being identified and/or offered the mental health treatment that could prevent suicide death (RCPsych, 2020). Efforts must be made on a local level to ensure the timely identification and engagement of at-risk individuals.

## Implemented Actions

### 01

Establishing translation and interpretation services to facilitate communication with non-English speaking service users, accessing both inpatient and community NMHS.

### 02

Establishing a protocol to guide seamless transition from inpatient care to community care for NMHS patients.

### 03

Offering psychological, social work, and other allied health services at Mater Dei Hospital, Sir Anthony Mamo Oncology Centre and Karin Grech Rehabilitation Hospital to support persons with acute, chronic, and terminal illnesses in a holistic manner.

### 04

Establishing the Gender Wellbeing Clinic in November 2018, which incorporates psychosocial support as part of a multidisciplinary care package.

### 05

The Ministry for Home Affairs, Security and Employment has trained all Correctional Services Agency (CSA) employees in mental health first aid and is continually expanding and training its psychosocial team within the Care & Reintegration Unit at Corradino Correctional Facility to promote inmates' rehabilitation and safeguard their mental wellbeing (TVM News, 2023; National Audit Office, 2021).

## Planned Actions

### 01

Enforce the inpatient to community National Mental Health Services transition protocol that proposes graded levels of support according to patients' unique needs, to ensure a seamless transition of care.

### 02

Provide training to gatekeepers to enable early detection of and early response to those at high risk for suicide.

### 03

Encourage the use of existing services through mental health promotion so that psychiatric care and psychological support are accessed in a timely manner.

### 04

Collaborate with NGOs and other agencies to establish a seamless referral pathway for postvention services to ensure the provision of psychological support for individuals bereaved and/or affected by suicide.

### 05

Collaborate with NGOs, local councils, and other community actors to cultivate a sense of community, promote social cohesion, and thereby prevent loneliness among vulnerable groups.

### 06

Collaborate with NGOs and other agencies to promote service-uptake of ancillary and specialised National Mental Health Services in the community.

### 07

Further develop services which offer mental health support for the LGBTIQ+ community, particularly for persons with gender dysphoria.

### 08

Increase the capacity of, and further develop, services within the area of addiction to ensure the provision of adequate mental health support to persons with substance use disorders, including alcohol use disorder.

### 09

Promote resilience courses provided by the Health Promotion and Disease Prevention Directorate (HPDP).

## 10

Encourage anti-racism and anti-xenophobia practices in accordance with the Anti-Racism Strategy 2021-2023 by the Human Rights Directorate and the EU's Anti-Racism Action Plan 2020-2025.

## 11

Offer cultural competence training to healthcare professionals.

## 12

Offer training on breaking bad news to healthcare professionals, particularly physicians working in general medicine and palliative care settings.

## Key Performance Indicators

**01**

Number of translation services provided.

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**02**

Number of attendees to resilience courses by HPDP.

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**03**

Number of healthcare professionals attending cultural competence training.

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**04**

Number of healthcare professionals attending training on breaking bad news.

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**05**

Number of patients supported during transition from inpatient to community care.

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**06**

Number of psychiatric re-admissions within two months of transition to community National Mental Health Services.

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**07**

National self-reported loneliness ratings.

Pillar 03

# Restriction of Means of Suicide

## Strategic Goal 4
## Diminish the suicide rate by restricting access to suicide means.

Limiting access to means of suicide is a universal evidence-based intervention for suicide prevention. Restriction of means should be tailored to the specific trends and needs of each country, depending on the methods that cause most deaths. Many persons who contemplate dying by suicide experience ambivalence about living or dying, and many do so in a time of acute distress. The restriction of lethal means convolutes suicidal planning and makes suicidal means less easily accessible, thereby affording the person contemplating suicide more time for the acute distress to pass, before taking fatal action (WHO, 2023).

In Malta, the most common modes of suicide in males are (i) hanging, strangulation or suffocation, (ii) jumping from a high place, and (iii) by using a firearm in descending order. In females, the commonest mode of suicide in a descending order are (i) jumping from a high place, (ii) hanging, strangulation or suffocation, and (iii) self-poisoning by medication (Camilleri, 2021; Renaud, 2019).

While it is challenging to identify effective approaches to reduce the incidence of suicide by hanging, there is potential for reducing other means of suicide. Restricting access to hotspots used for jumping may be achieved through making site access more difficult. Hotspots for suicide by jumping were identified through a study conducted by Camilleri in 2021. The study found that the general public's perception was that most suicides by jumping happened at Dingli Cliffs, however, data shows that most suicides by jumping occur at the Valletta bastions and the Mosta bridge. The latter had a preventative fence installed in 2016 with the aim of hindering suicide attempts. Although there is no published research measuring the efficacy of this fence, one newspaper article had reported a reduction in suicides at the Mosta bridge in 2017, one year from the fence's installation (Times of Malta, 2017).

The Medicines Authority (2022) has enabled legislation that restricts the availability of medicinal products such as analgesics, by mandating smaller pack sizes, with the intention of safeguarding against misuse, overdose, or a delay in seeking medical attention.

In healthcare settings, especially in mental health facilities, it is critical to minimise environmental risks for self-harm and suicide by ensuring safe infrastructure that prevents jumping from heights, scaling of boundary walls, and ligature points. For mental health facilities to be safe places of care, it is also imperative to mitigate other risks by ensuring the safe storage of medications, the removal of ligature materials, and the confiscation of illicit substances. In addition, patients should not have access to items that are dangerous or may lead to harm to self or others or facilitate their or others' abscondment during psychiatric hospitalisation. A balance between safety versus privacy and dignity should be sought to ensure appropriate therapeutic environments and optimal patient care (Care Quality Commission, 2023).

## Implemented Actions

### 01

Safe storage of dangerous drugs in all inpatient wards, in accordance with the Dangerous Drug Ordinance (2020) and the Controlled Drugs Policy.

---

### 02

During psychiatric hospitalisation, authorised staff members regularly search patients and/or their belongings to ensure the safety of the patients, visitors, and staff. Since searches are intrusive and may impinge upon patients' rights, every effort should be made to prevent or defuse situations in which searches may need to be considered, and to uphold patient dignity when searches are conducted.

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## Planned Actions

### 01

The placing of posters with positive and hopeful messages at hotspots, with the aim of making suicide-contemplators reconsider their actions.

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### 02

The placing of phonebooths in suicide hotspots having direct access to 112.

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### 03

The erection of preventative fences and/or barriers at additional suicide hotspots, as identified through local research.

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### 04

Regular police patrols at hotspots.

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### 05

The minimisation of access to ligature points in mental health facilities, particularly when designing new premises, wards, or hospitals.

## Key Performance Actions

### 01

Number of phonebooths placed at hotspots.

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### 02

Number of preventative fences and/or barriers erected.

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### 03

Number of police patrols at hotspots.

Pillar 04

# Awareness and Knowledge

## Strategic Goal 5
## Media reporting is responsible and societal mental health literacy is improved.

There is evidence that media reports about suicide can enhance or weaken suicide prevention efforts. An increase in suicide deaths is often observed following widely disseminated stories of death by suicide, whereas stories centred on overcoming a suicidal crisis have a protective factor and often result in fewer suicides (WHO, 2023b). The dissemination and application of the 'Recommendations for Media on Reporting Non-Suicidal SelfInjury and Suicide' issued by the Malta Association of Psychiatrists (2021) has been an important initiative for local suicide prevention. Sensitising the media on the importance of responsible reporting is a cornerstone to reducing the stigma on mental illness and suicide, as well as curbing suicide deaths. The media is a valuable tool for the communication of positive mental health trajectories and messages, and for the dissemination of information about existing healthcare services and pathways of care.

Awareness-raising and advocacy are strategic actions which contribute to overall suicide prevention efforts by influencing decision-makers and public opinion, attitudes, and behaviours. By improving awareness, communities observe increased help-seeking behaviours and service demand, thereby creating an optimal opportunity for early detection and intervention (WHO, 2021).

A mental health campaign entitled 'Ħu Ħsieb' [Take Care] was launched in 2023 under the auspices of the Ministry for Health. The campaign adopted both a universal and targeted approach. The principal objectives were to promote healthy life habits which are conducive to mental and physical wellbeing, and to encourage help-seeking through available National Mental Health Services or through the dedicated National Mental Health Helpline – 1579.

Initiatives on mental health promotion are ongoing, with various distinct stakeholders endeavouring to raise awareness on the importance of mental wellbeing across the life course. Despite the health and education sectors being at the forefront of these endeavours, local councils and several NGOs have also ventured in raising awareness and creating a sense of communal belonging. Additionally, NMHS and the HPDP collaborate to organise digital informational and awareness-raising material for World Suicide Prevention Day. As public and professional demand for knowledge on mental health increases, as does the demand for National Mental Health Services following the COVID-19 pandemic, various agencies have started to organise seminars, webinars, and other fora for knowledge-exchange on mental wellbeing.

Suicide is a serious public health issue that warrants attention. Media reporting may collaborate with mental health promotion efforts to improve mental health literacy, to reduce stigma by dispelling myths about mental illness and suicide, and to provide information on where to seek help thus encouraging improved mental health outcomes.

## Implemented Actions

### 01

Collaborating with the media and sharing guidelines on the reporting of suicidal behaviour, in line with WHO guidelines.

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### 02

Collaborating with the HDPD for awareness-raising campaigns and/or interventions.

---

## Planned Actions

### 01

Develop a protocol of alerting media houses that do not follow shared guidelines on the reporting of suicidal behaviour so that their narrative may be reviewed.

### 02

Work with the Education Department to formally incorporate resilience training in the school curriculum spanning throughout the entire compulsory education period.

### 03

Upgrade the digital infrastructure used to highlight steps to take during a mental health crisis, available National Mental Health Services, self-help toolkits, and resilience programmes.

### 04

Use various digital platforms to reach a wide audience whilst promoting mental health awareness messages.

### 05

Work with local councils to support mental wellbeing initiatives and to improve communal social cohesion, with the aim of fostering a sense of belonging and preventing loneliness.

## Key Performance Indicators

### 01

Number of meetings/communications with media, local councils, and the Education Department.

### 02

Collaborating with the HDPD for Establishment of user-friendly digital infrastructure for NMHS. and/or interventions.

Pillar 05

# Prevention and Health Promotion Activities

## Strategic Goal 6
## Endorse mental health promotion and prevention activities and prioritise wellbeing along the life course.

Suicide prevention must be targeted towards different stages along the life course to counteract distinct life stressors at the various life stages. Disease prevention and health promotion activities include the promotion of wellbeing (primary prevention), early intervention, recovery, and postvention.

Public health campaigns by the Health Promotion and Disease Prevention (HPDP) Directorate have focused on mental wellbeing as a form of primary prevention in recent years. The HPDP Directorate delivers regular online programmes with the aim of helping the individual to strengthen resilience, using the strategic motto 'Turn Challenge into Change and Stress into Success: Build Your Resilience'. Weekly sessions are conducted in small groups for a period of seven weeks, wherein information is provided, discussion is prompted, and take-home activities are encouraged. Age-appropriate resilience training is also being offered by the Education Department to school children on an ad hoc basis.

In addition, the Recovery and Wellbeing Academy (RAWA) was launched by NMHS in 2023. The RAWA co-produced coursework by mental health professionals and persons with lived experience of mental illness which was freely available to the public through a series of lectures. The modules aimed to promote self-help methods for improved mental wellbeing, to increase awareness about mental health, and to ameliorate societal mental health literacy and support recovery. Collaboration with other European Academies is underway.

Early intervention can be facilitated through increased public awareness about early warning signs of mental distress and/or disorders, through screening in primary care, and through gatekeeper identification. The Emergency and Stabilisation services that have been highlighted in Pillar 2A bridge the gap between early intervention and recovery, once service users enter the mental health system.

All inpatient and community services falling under NMHS will eventually receive training on suicide risk assessment and management to promote rigorous containment of persons experiencing a suicidal crisis. Additionally, it is planned that formal safety planning becomes an integral part of all acute National Mental Health Services as a means of safety-netting and suicide prevention.

Postvention services remain paramount to persons who have been bereaved by suicide or have been significantly affected by suicidal behaviour in any other manner. By accessing postvention services, affected individuals are equipped to process traumatic events and to bolster their mental wellbeing, thereby preventing additional suicidal behaviour on the affected individual's part.

For mental health professionals and other healthcare professionals to be able to do their job effectively, their wellbeing needs to be ensured. To this end, support must be readily available and easily accessible as and when required, without any form of judgment or prejudice.

## Implemented Actions

### 01

Establishing the Recovery and Wellbeing Academy, which will continue to offer courses.

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### 02

Collaborating with the HPDP Directorate for awareness-raising campaigns and/or interventions.

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### 03

Training of part of the NMHS workforce in suicide risk assessment and management.

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### 04

Support is provided to mental health professionals and other healthcare professionals at the workplace through organisational psychological support schemes.

## Planned Actions

### 01

Train the whole NMHS workforce in suicide risk assessment and management.

### 02

Offer in-house training on safety planning to professionals working within the national acute National Mental Health Services.

### 03

Formalise and endorse the safety plan document that is to be used within NMHS and encourage its use within acute National Mental Health Services, and any other services where it is deemed beneficial to service users.

### 04

Continue to collaborate with the HPDP for mental health promotion and suicide prevention activities, using digital media as a vessel at every applicable opportunity.

### 05

Work with primary care services to highlight the importance of early intervention through screening for depression and suicidal behaviour and offering specialist training and support as required.

### 06

Continue to bolster emergency and stabilisation services, extending the CRHT service to 24hour/7-day operations.

## Key Performance Indicators

### 01

Number of NMHS mental health professionals successfully completing suicide risk assessment and management training.

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### 02

Number of NMHS mental health professionals successfully completing in-house training on safety planning.

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### 03

Number of meetings with primary care services.

---

### 04

Number of specialist training sessions provided to the primary health workforce in relation to screening for depression and suicidal behaviour.

---

### 05

Number of collaborations with the HPDP Directorate.

---

### 06

Endorsement of a formal safety plan document for NMHS.

Pillar 06

# Quality Assurance and Expertise

## Strategic Goal 7

## Improve data collection practices in relation to suicidal behaviour to inform future policies, programmes, and services.

Our approach to suicide prevention is well-planned and delivered, through a whole-of-government approach in collaboration with other stakeholders such as NGOs and persons with lived experience. We improve our approach through regular monitoring, evaluation, and review.

The effectiveness of our actions will be monitored and measured through selected key performance indicators at distinct points in time.

Documentation of actions are collected in a timely manner and analysed yearly. The results will then be discussed by the monitoring team and any actions tweaked as deemed necessary.

**Suicide Mortality Register**

It is acknowledged that psychological autopsy reporting is not common practice in Malta. Hence, it is difficult to capture qualitative data on the precipitating factors for each suicide registered in Malta. However, there is commitment to publish a brief yearly report on suicide mortality with the following enlisted variables:

- age,
- gender,
- locality of residence,
- method of suicide,
- place of suicide,
- contact with primary care services within 30 days and one year prior to suicide death (using data from the electronic patient record system), and
- contact with National Mental Health Services within 30 days and one year prior to suicide death (using data from the electronic patient record system).

## Implemented Actions

**01**

The submission of a proposal for an electronic self-harm register.

## Planned Actions

**01**

Improving data collection within NMHS.

**02**

Establishing a self-harm register, inclusive of NSSI and suicide attempts, if the above submitted proposal is approved.

**03**

Drafting of an annual suicide mortality report in conjunction with the Directorate of Health Information and Research (DHIR).

## Key Performance Indicators

**01**

Drafting of annual report for NMHS.

**02**

Drafting of annual suicide mortality report.

**03**

Annual analysis of actions related to Suicide Prevention Strategy.

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# Appendix 01

# Myths and Facts About Suicide

In Malta, suicide and self-harm are complex issues influenced by various personal and societal factors, including individual circumstances, societal pressures, emotional resilience, life events, and biological factors. The progression from suicidal thoughts to non-fatal self-harm and, in severe cases, suicide, reflects a process shaped by unmet psychological needs and feelings of hopelessness, entrapment, and disconnection. Overcoming the misconception that suicide is inevitable is crucial, as it allows for effective prevention efforts guided by the World Health Organization's insights.

Understanding the complexities of suicide involves recognising factors like impulsivity, alcohol consumption, access to means, and exposure to suicide through media. By challenging myths surrounding suicide, Malta can develop more effective prevention strategies. These efforts aim to dismantle barriers to support and intervention, fostering a society where individuals in distress receive the help they need.

## 01

Talking about suicide is a bad idea and can be interpreted as encouragement to take one's own life.

**Talking openly about suicide can allow the person to consider other options or to take the time to rethink his/her decision, thereby preventing suicide. It does not lead to someone taking their life.**

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## 02

People who talk about suicide do not really intend to do it.

**A significant number of people contemplating suicide are experiencing emotional pain and distress, anxiety, depression and hopelessness, and may feel that there is no other option. Speaking about suicidal thoughts and feelings needs to be taken seriously as some persons might proceed to act on their suicidal feelings.**

## 03

Someone who is suicidal is determined to die.

**On the contrary, studies suggest that people who are suicidal are often ambivalent about living or dying and they just want relief from their pain. Someone may act impulsively and die a few days later, even though they would have liked to live on. Access to emotional support at the right time may prevent suicide. Studies with individuals who have made near-fatal suicide attempts indicate that many of them are pleased later on that they survived.**

## 04

Most suicides happen without warning.

**Some suicides occur without warning; however, most have been preceded by warning signs, whether verbal (e.g. by saying "I will kill myself") or behavioural (e.g. by buying the means to take one's life). This is why it is important to know what the warning signs are and look out for them.**

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## 05

Once someone is suicidal, he or she will always remain suicidal.

**Acute suicide risk is often short-term and may be specific to a mix of factors that are significant for the person at the time. While suicidal thoughts may return, they are not permanent and a person who has previously thought about suicide or made a suicide attempt may not have these thoughts again. Frequently people do not take steps again to end their life.**

## 06

Only people with mental health conditions are suicidal.

**Many people who are suicidal do not have a mental health condition, and many people with mental health conditions do not have a wish to die. In suicidal crisis situations, many underlying and contributing factors need to be considered – such as acute emotional distress, chronic pain, experience of violence, and social determinants.**

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## 07

Suicidal behaviour is easy to explain.

**Suicidal behaviours are not easy to explain. They are never the result of a single factor or event. The factors that lead individuals to take their own life are multiple and complex and should not be reported in a simplistic way. Health, mental health, stressful life events, and social and cultural factors need to be considered when trying to understand suicidal behaviour.**

## 08

Suicide is a way people use to cope with problems.

**It is best not to portray suicide as a constructive or appropriate means of coping with problems. Stories about individuals with personal experience of suicidal thoughts and who managed to cope with their difficult life situations can help to highlight alternative options for others who might currently be contemplating suicidal behaviour.**

## Appendix 02

# A Summary of The National Mental Health Services

### Inpatient Services

**Acute Psychiatry**
Admission Wards, MCH

**Provided by** MDT

**Client Group**
Persons ≥18yrs with an acute mental health disorder, who may not be cared for in a community setting

**Referred by**
Psychiatrists, CMHTs, CRHT, Emergency Psychiatric Service (EPS), Psychiatry Liaison Service (PLS), GPs

**Long-Term Psychiatry**
Admission & Long-term Wards, MCH

**Provided by**MDT

**Client Group**
Persons ≥18yrs with a complex and/or chronic mental health disorder, who may not be cared for in a community setting

**Referred by**
Psychiatrists, CMHTs, CRHT, Emergency Psychiatric Service (EPS), Psychiatry Liaison Service (PLS), GPs

**Old Age Acute Psychiatry**
Old Age Psychiatry Ward, MCH

**Provided by** MDT

**Client Group**
Persons ≥65yrs with a complex or long-term disorder, who may not be cared for in a community setting

**Referred by**
Psychiatrists, CMHTs, CRHT, Emergency Psychiatric Service (EPS), Psychiatry Liaison Service (PLS), Geriatricians, Doctors at SVPR & KGH, GPs

**Child & Adolescent Psychiatry**
Young People's Unit, MCH

**Provided by** MDT

**Client Group**
Children & adolescents <18yrs with an acute mental health disorder, who may not be cared for in a community setting

**Referred by**
Psychiatrists, Child and Young People's Services (CYPS), Child, Adolescent and Youth Services (CAYS), Child, Adolescent Psychiatric Emergency Service (CAPES), Crisis Intervention and Home Treatment (CIHT), Psychiatry Liaison Service (PLS), GPs, Paediatricians

**Substance Abuse Psychiatry**
Substance Use Disorder &
Dual Diagnosis Wards, MCH

**Provided by** MDT

**Client Group**
Persons with dual diagnosis or substance use disorder

**Referred by**
Psychiatrists, CMHTs, EPS, PLS, GPs working in addictions, NGOs (Sedqa, Caritas, Oasi)

**Psychiatry Liaison Service**
MDH

**Provided by** Psychiatrists,
Psychiatric Nurses, Social Worker

**Client Group**
Inpatients with psychiatric conditions within MDH

**Referred by**
Doctors at MDH

**Old Age Psychiatry**
SVPR KGH

**Provided by** incl. Geriatrician

**Client Group**
Persons ≥60 years with a mental health disorder, who require residential care

**Referred by**
Psychiatrists, PLS, Geriatricians, Doctors at SVPR & KGH

**Eating Disorders Inpatient Service**
Fondazzjoni Kenn Għal Saħħtek

**Provided by** MDT

**Client Group**
Persons with an eating disorder and/or morbid obesity, who require inpatient admission

**Referred by**
GPs, Psychiatrists

**Gozo General Hospital (GGH)**
Short Stay Psychiatric Unit, GGH

**Provided by** MDT

**Client Group**
Adults with an acute mental health disorder (incl. substance use disorders and intellectual disability), who may not be cared for in a community setting

**Referred by**
Psychiatrists, GPs, Doctors at GGH

## Crisis Services

**Emergency Psychiatric Service (EPS)**
A&E Department, MDH

**Provided by** PLS (AM), Psychiatry Duty Doctors (PM)

**Client Group**
Persons ≥18yrs who present to A&E with an acute psychiatric problem or in a mental health crisis

**Referred by**
Self-referral, Doctors at A&E, Professionals from NMHS, Mental health professionals, GPs

**Crisis Resolution Home Treatment (CRHT)**
Based at CRHT Clinic I/o MCH; service is provided within the community setting

**Provided by** Psychiatrists, Nurses

**Client Group**
Persons ≥18yrs in a mental health crisis, who may be cared for in a community setting

**Referred by**
EPS, PLS

**Child and Adolescent Psychiatric Emergency Service (CAPES)**
A&E Department, MDH

**Provided by** PLS (AM), Psychiatry Duty Doctors (PM), YPU nurses

**Client Group**

Children and adolescents <18yrs who present to A&E with an acute psychiatric problem or in a mental health crisis

**Referred by**

Self-referral, Doctors at A&E, Mental health professionals, GPs, Paediatricians School counsellors, residential homes

**Crisis Intervention and Home Treatment (CIHT)**
Based at YPU, MCH; service is provided within the community setting

**Provided by** MDT

**Client Group**
Children and adolescents <18yrs in a mental health crisis, who may be cared for in a community setting

**Referred by**
CAPES, CYPS, Psychiatrists

**24/7 National Mental Health Helpline**
Based at MCH

**Provided by** Psychologists, Psychology Assistants

**Client Group**
Any person who calls the helpline

**Referred by**
Self-referral

## Community Services

**Outpatient Service at MCH**
Ċentru Tommaso Chetcuti (ĊTC), MCH

**Provided by** MDT

**Client Group**
Persons ≥18yrs who are 'on leave' from hospital admission

**Referred by**
Psychiatrists

**Community Mental Health Teams (CMHTs)**
Mental Health Clinics at Mtarfa, Qawra, Mosta, Floriana, Cospicua & Paola

**Provided by** MDT

**Client Group**
Persons ≥18yrs in a mental health crisis, who may be cared for in a community setting

**Referred by**
EPS, PLS

**Outreach Teams**
Zone 1 (South): Cospicua CMHC
Zone 2 (Central): Floriana CMHC
Zone 3 (North): CTC, MCH
Zone 4: Gozo

**Provided by** Nurses, Healthcare assistants

**Client Group**
Persons ≥18yrs with a chronic or complex mental health disorder, who may or may not be on a Community Treatment Order (CTO) and who may be cared for in a community setting

**Referred by**
Professionals from NMHS

**Community Rehabilitation Centres**
Day Centres at Qormi, Cospicua, Paola & Żejtun

**Provided by** Occupational Therapists

**Client Group**
Persons ≥18yrs with a mental health disorder who require skills re-/training to achieve a more independent and autonomous life in a community setting

**Referred by**
Professionals from NMHS

## Specialised Services

**Child and Young People's Services (CYPS)**
St Luke's G'Mangia

**Provided by** MDT

**Client Group**
Children and adolescents <18yrs with a mental health disorder, who may be cared for in a community setting

**Referred by**
Psychiatrists, mental health professionals from YPU, CAPES & CIHT, GPs, School counsellors, Paediatricians

**Child, Adolescent and Youth Services (CAYS)**
Victoria, Gozo

**Provided by** MDT

**Client Group**
Children and adolescents <18yrs with a mental health disorder, who may be cared for in a community setting

**Referred by**
Psychiatrists, mental health professionals from YPU, CAPES & CIHT, GPs, School counsellors, Paediatricians

**Substance Abuse Psychiatry**
Dual Diagnosis Clinics at Cospicua CMHT & Addictions Clinic, GGH

**Provided by** MDT

**Client Group**
Persons with dual diagnosis or substance use disorder

**Eating Disorders Service**
Fondazzjoni Kenn Għal Saħħtek

**Provided by** MDT

**Client Group**
Persons with an eating disorder and/or morbid obesity, who may be cared for in a community setting

**Referred by**
GPs, Psychiatrists

**Neuropsychiatry**
MDH Outpatients & GGH Outpatients

**Provided by** Psychiatrists & Neuropsychology Practitioners

**Client Group**
Patients with neuropsychological problems

**Referred by**
Psychiatrists, Neurologists, Physicians, GPs

**Perinatal Mental Health Team**
Antenatal Clinic, MDH, Rabat Health Centre, Qormi Health Centre, Mosta Health Centre & GGH Outpatients

**Provided by** MDH incl. Obstetricians

**Client Group**
Women planning pregnancy, expectant mothers, and women up to one year postpartum

**Referred by**
Self-referrals, all health care professionals in contact with service users

**Old Age Psychiatry  Community Services**
KGH, SVPR, Residential homes & Home Assessment

**Provided by** Psychiatrists, Psychologist, Geriatrician

**Client Group**
Persons ≥60 years with a mental health disorder, who require residential care or persons ≥60 years with cognitive impairment who live in the community and who are unable to attend outpatient appointment

**Referred by**
Psychiatrists, PLS, Geriatricians, Doctors at SVPR & KGH, Dementia Intervention Team, GPs

**Student Wellbeing Services**
University of Malta & MCAST

**Provided by** Psychiatrists, Psychologists, Counsellors

**Client Group**
Students and staff of educational institutions

**Referred by**
Self-referrals, Psychiatrists

**Intellectual Disability Services**
CYPS, CAYS, Qormi CMHC, Paola CMHC, Psychiatric Outpatients GGH, Dar tal-Providenza, Casal Nuovo, Paola & GGH Outpatient

**Provided by** MDT

**Client Group**
Children, adolescents and adults with an intellectual disability, who may be cared for in a community or residential setting

**Referred by**
Psychiatrists, CMHTs, EPS, PLS, GPs

**Psychiatric Outpatients**
GGH

**Provided by** MDT

**Client Group**
Adults with a mental health disorder, who may be cared for in a community setting

**Referred by**
Psychiatrists, GPs, Doctors at GGH

## Interventional Services

**Electroconvulsive Therapy (ECT)**
Theatres, MDH & GGH

**Provided by** Psychiatrist, Nurses, Anaesthetist

**Client Group**
Persons ≥18yrs with a severe/treatment-resistant psychiatric disorder

**Referred by**
Caring psychiatrist, and a review by a second specialist in psychiatry

**Transcranial Magnetic Stimulation (TMS)**
TMS Clinic, MCH

**Provided by** Psychiatrist, Psychiatric Nurses

**Client Group**
Persons ≥18yrs with treatment resistant depression and/or OCD

**Referred by**
Psychiatrists

# Appendix 03

# List of Consulted Stakeholders

**WP6 Advisory Board**

**Dr Stephanie Xuereb**
Consultant Public Health & CEO
National Mental Health Services

**Professor Anton Grech**
Consultant Psychiatrist & Chairperson
National Mental Health Services

**Dr Victoria Sultana**
Director of Nursing
National Mental Health Services

**Dr David Cassar**
Consultant Psychiatrist
National Mental Health Services and
Head, Department of Psychiatry, University of Malta

**Dr Marija Axiak**
Consultant Psychiatrist
National Mental Health Services

**Dr Maria Bezzina Xuereb**
Consultant Psychiatrist
National Mental Health Services

**Dr Anthony Zahra**
Consultant Psychiatrist
National Mental Health Services

**Dr Giovanni Grech**
Consultant Psychiatrist
National Mental Health Services

**Dr Miriam Camilleri**
Consultant Public Health
Commissioner for Mental Health

**Dr Kathleen England**
Consultant Public Health
Department for Policy in Health

**Dr Patrick Farrugia**
Consultant Emergency Medicine & Chairperson
Emergency Department, Mater Dei Hospital

**Dr Kirsten Schembri**
General Practitioner
Primary Health Care

**Dr Marta Santa**
Senior Lecturer
Department of Psychology, University of Malta

**Professor Josianne Scerri**
Professor
Department of Mental Health, University of Malta

**Ms Jeanette Falzon**
Executive Allied Health Practitioner
Gozo General Hospital

**Ms Graziella Castillo**
Director
Aġenzija Appoġġ, FSWS

**Mr Karl Paul Coleiro**
Counsellor
National School Support Services (NSSS)
Ministry for Education

**Ms Josette Camilleri**
Assistant Head
Ministry for Education

**Ms Daniela Calleja Bitar**
CEO
Richmond Foundation

**Ms Claudia Taylor East**
CEO
SOS Malta

**Mr Christopher Siegersma**
CEO
Correctional Services Agency

**Superintendent Sylvana Gafà**
Head of Services
Victim Support Agency

**Ms Julianne Grima**
Executive Chairperson
Victim Support Malta

**Mr Karl Grech**
Director
Victim Support Malta

**Mr Clayton Mercieca**
Head
Sexual Orientation, Gender Identity, Gender Expression and Sex Characteristics (SOGIGESC)
Unit Human Rights Directorate

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|---|---|
| **Health and Wellbeing** | **Community Leadership Team**<br>Mr Joseph Galea, Ms Josephine Cassar, Ms Cathleen Grima |
| | **Psychiatry Liaison Team, Mater Dei Hospital**<br>Dr Joseph Cassar, Dr Maria Bezzina Xuereb, Dr Daniela Zammit, Mr Gary Brincat |
| | **Practice Development Unit, National Mental Health Services**<br>Mr Kevin Gafà, Mr Stephen Demicoli |
| | **Psychology Department, National Mental Health Services**<br>Ms Cynthia Bonnici |
| | **Psychology Department, Mater Dei Hospital** |
| | **Psychology Department, Gozo General Hospital** |
| | **Accident and Emergency Department, Mater Dei Hospital** |
| | **Active Ageing and Community Care** |
| | **Allied Health Directorate**<br>Dr Rita Micallef & Ms Maria Busuttil |
| | **Employment Support Services**<br>Ms Chantelle Sciberras |
| | **University of Malta Counselling Services** |
| | **MCAST Counselling Services** |
| **Academia** | **Department of Psychology, University of Malta** |
| | **Department of Mental Health, University of Malta**<br>Prof Paulann Grech, Prof Michael Galea, Dr Alexei Sammut, Ms Christie Attard |
| **Social Welfare** | **Foundation for Social Welfare Services (FSWS)**<br>Mr Alfred Grixti |
| | **Aġenzija Appoġġ (FSWS)**<br>Ms Graziella Castillo |
| | **Sedqa (FSWS)**<br>Mr Melchiore Ellul |
| | **Caritas**<br>Mr Anthony Gatt |
| | **Commission for the Rights of Persons with Disability**<br>Ms Rodha Garland |
| **Education** | **Malta Diocese**<br>Dr Rebecca Gatt, Ms Ruth D'Amato, Dr Patricia Bonello, Ms Anna Lisa Grech, Mr Paul Cutajar |
| | **National School Support Services (NSSS)**<br>Dr Josanne Ghirxi, Ms Marija Zahra<br>Mr Stanley Zammit, Mr Karl P Coleiro |

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|---|---|
| **Uniformed and Security** | **Malta Police Force**<br>Director General Ms Stefania Sgandurra,<br>Superintendent Dr Melvyn Camilleri<br><br>**Superintendent Sylvana Gafà**<br><br>**Correctional Services Agency**<br>Dr Kevin Sammut Henwood |
| **Media** | **Lovin Malta**<br>Mr David Grech Urpani<br><br>**Times of Malta**<br>Ms Diana Cacciattolo<br><br>**Calypso Radio** |
| **Voluntary Organisations and Associations** | **FIDEM Foundation**<br><br>**SOS Malta**<br><br>**St Jeanne Antide Foundation**<br>Ms Melanie Piscopo<br><br>**Malta Trust Foundation**<br>President Emeritus Marie-Louise Coleiro Preca<br><br>**Mental Health Association (MHA) Malta**<br>Ms Simone Borg<br><br>**MHA Gozo**<br>Ms Jeanette Falzon and Ms Pauline Camilleri<br><br>**Malta Association of Psychiatrists (MAP)**<br>Dr Sacha Taylor-East<br><br>**Malta Association of Psychiatric Nurses (MAPN)**<br>Mr Mark Vassallo<br><br>**Malta Association of Occupational Therapists (MAOT)**<br>Mr Demis Cachia<br><br>**Malta Chamber of Psychologists (MCP)**<br>Ms Gail Debono<br><br>**Malta Psychology Profession Board (MPPB)**<br>Ms Jo Christine Scicluna<br><br>**Malta Gay Rights Movement (MGRM)**<br><br>**Drachma**<br><br>**Relationships are Forever Foundation**<br><br>**Richmond Foundation**<br><br>**Malta Local Councils Association** |
| **Experts by Experience** | Anonymous |

It should be noted that while additional individuals and/or organisations were invited to participate, they declined the invitation and have therefore not been included in the list above.

## Coordination and Organisation

**Set up a committee within the Ministry for Health and Active Ageing (MHA) to steer and coordinate the actions of the strategy – NSPS Committee.**

**Implementation by**
NMHS, MHA

**Measure**
Number of meetings

**Target Value**
6 meetings per year

**Set up a committee composed of inter-ministerial and extra-ministerial stakeholders, NGOs and other entities to facilitate the actions of the strategy – Multistakeholder Committee.**

**Implementation by**
NSPS Committee

**Measure**
Number of meetings

**Target Value**
4 meetings per year

**Conduct an evaluation of the strategy, including actions performed and KPIs achieved, mid-way through the strategy's stipulated 5-year period.**

**Implementation by**
NSPS Committee

**Measure**
Strategy Review

**Target Value**
1

## Support and Treatment

**A qualified mental health professional will provide training on suicide risk assessment and management to all inpatient NMHS mental health professionals.**

**Implementation by**
NMHS

**Measure**
% inpatient NMHS mental health professionals trained

**Target Value**
100%

**Implement a training needs analysis for health care professionals frequently working with persons in suicidal crisis, e.g. Ambulance and A&E staff.**

**Implementation by**
NSPS Committee

**Measure**
Training needs identified;
Number of meetings with HCPs

**Target Value**
2 per year

**Identify key gatekeepers who would benefit from training on suicide risk assessment and management.**

**Implementation by**
NSPS Committee, Multistakeholder Committee

**Measure**
Number of identified gatekeepers;
Number of meetings with gatekeepers

**Target Value**
2 per year

**Provide identified gatekeepers with said training.**

**Implementation by**
NMHS, NSPS Committee

**Measure**
% gatekeepers successfully completing training

**Target Value**
80%

**Support gatekeepers in establishing protocols at the workplace/schools to minimise suicide risk and to provide timely support for at-risk persons and other persons who may be affected.**

**Implementation by**
NMHS, NSPS Committee

**Measure**
Number of protocols established

**Target Value**
1 per year

**Prioritise patients' right to privacy and dignity during psychiatric assessment at the A&E Department at Mater Dei Hospital by securing a private area for mental health assessment.**

**Implementation by**
Mater Dei Hospital Management

**Measure**
Private area secured

**Target Value**
As required

**A newly built acute mental health wing within the perimeter of Mater Dei Hospital is inaugurated to provide acute mental health care in a destigmatised, dignified, and therapeutic environment.**

**Implementation by**
MHA

**Measure**
Facility is built and inaugurated

**Target Value**
1

**To gradually increase the complement of healthcare professionals to assist patients in mental health crisis.**

**Implementation by**
NMHS, NSPS Committee

**Measure**
Number of interventions by the CRHT team

**Implement the inpatient to community National Mental Health Services transition protocol that proposes graded levels of support according to patients' unique needs, to ensure a seamless transition of care.**

**Implementation by**
NMHS

**Measure**
Number of patients supported; Number of psychiatric readmissions within 2 months of transition to community National Mental Health Services

**Target Value**
<50% readmission rate

**Establish a seamless referral pathway for postvention services to ensure the provision of psychological support for individuals bereaved and/or affected by suicide.**

**Implementation by**
NMHS, Multistakeholder Committee

**Measure**
Postvention services ongoing

**Target Value**
1

## Restriction of Means of Suicide

**Placing of posters with positive and hopeful messages at hotspots, with the aim of making suicide-contemplators reconsider their actions.**

**Implementation by**
Multistakeholder Committee

**Measure**
Posters and infographics placed

**Placing of phonebooths in suicide hotspots having direct access to 112.**

**Implementation by**
Multistakeholder Committee, Malta Information Technology Agency, Ministry for Transport, Infrastructure and Public Works

**Measure**
Phonebooths placed

**Erection of preventative fences and/or barriers at additional suicide hotspots.**

**Implementation by**
Multistakeholder Committee, Ministry for Transport, Infrastructure and Public Works

**Measure**
Preventative fences and/or barriers erected

**Regular police patrols at suicide hotspots.**

**Implementation by**
Malta Police Force

**Measure**
Number of police patrols; Number of police interventions at suicide hotspots

## Awareness and Knowledge

**Develop a protocol of alerting media houses that do not follow shared guidelines on the reporting of suicidal behaviour so that their narrative may be reviewed.**

**Implementation by**
Multistakeholder Committee

**Measure**
Protocol established; Number of meetings/ communications with media

**Target Value**
1

**Work with the Education Department to formally incorporate resilience training in the school curriculum spanning throughout the entire compulsory education period.**

**Implementation by**
Resilience training formally embedded in academic curriculum; Number of meetings/ communications with education department

**Measure**
Resilience training formally embedded in academic curriculum; Number of meetings/ communications with education department

**Target Value**
1

**Upgrade the digital infrastructure used to highlight steps to take during a mental health crisis, available National Mental Health Services, selfhelp toolkits, and resilience programmes.**

**Implementation by**
NMHS, Malta Information Technology Agency

**Measure**
Digital infrastructure updated

**Target Value**
1

## Prevention and Health Promotion Activities

**Offer in-house training on safety planning for acute National Mental Health Services within NMHS.**

**Implementation by**
NMHS

**Measure**
% mental health professionals successfully completing training

**Target Value**
80%

**Formalise and endorse the safety plan document that is to be used within NMHS.**

**Implementation by**
NMHS

**Measure**
Safety plan endorsed

**Target Value**
1

**Continue mental health promotion and resilience training to prevent suicide.**

**Implementation by**
NSPS Committee, HPDP

**Measure**
Number of collaborations with the HPDP Directorate

**Immediate accessibility services in times of crisis.**

**Implementation by**
NMHS, NSPS Committee

**Measure**
24-hour in person service

## Quality Assurance and Expertise

**Improve data collection practices related to mental disorders, self-harm, and suicidal behaviour.**

**Implementation by**
NMHS

**Measure**
Improved data

**Draft a brief annual suicide mortality report in conjunction with the Directorate of Health Information and Research (DHIR).**

**Implementation by**
NMHS, DHIR

**Measure**
Annual report