

A National Suicide Prevention Strategy for Malta

2026-2031



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 Department 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 ImPEMENTAL** 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.

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A painting by a user of the National Mental Health Services

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. I must congratulate and thank Dr Antonella Sammut for leading the meticulous research effort and for penning the first draft of this document. 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 Centre (APC) 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.

Public Consultation

The Ministry for Health and Active Ageing has produced the National Suicide Prevention Strategy 2026-2031. 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 pre-consultation internal and external 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 persons with a history of suicidal behaviour and those bereaved by suicide was held. Following the pre-consultation phase, strong political commitment was secured for the National Suicide Prevention Strategy. Subsequently, the draft Strategy was presented for comprehensive public consultation from 24 March 2025 to 16 May 2025, inviting input from the general public and institutional stakeholders. All feedback received during this consultation was carefully evaluated and, where appropriate, integrated into the final Strategy. The engagement of a broad range of stakeholders has ensured that the Strategy includes actionable measures aimed at empowering individuals experiencing suicidal thoughts and behaviours, fostering a supportive environment conducive to mental wellbeing, and advancing the development of person-centered care tailored to diverse needs.

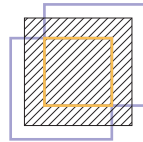
Executive Summary

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).

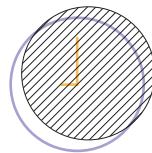
This is the first National Suicide Prevention Strategy for Malta, which has been produced by National Mental Health Services, under the auspices of the Ministry for Health and Active Ageing, in collaboration with valued stakeholders from several disciplines. The inclusion of experts by experience in 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



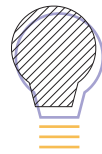
Joint activities and cross-boundary collaboration performed by diverse ministries, public agencies, and voluntary organisations to provide a comprehensive plan of action for National Suicide Prevention.



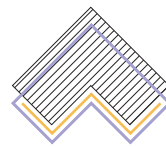
The provision of timely and sufficient support and treatment to persons at-risk of suicide, and their caregivers.



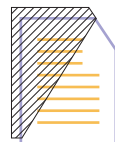
Gatekeeper training, robust emergency and stabilisation services, and targeting of high-risk groups. These strategies are complemented with strategies geared at further restriction of suicide means.



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.

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 and 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

HBSC

Health Behaviour in School-aged Children

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

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. (2022) 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). Meta-analytic research demonstrates that autistic individuals are nearly three times more likely to die by suicide compared to non-autistic individuals, with autistic females exhibiting an even higher risk, approaching a pooled relative risk of four, compared to autistic males (Santomauro et al., 2024). 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.

In recent decades, social media and Internet use have expanded dramatically, evolving from platforms for social interaction and entertainment into indispensable tools for work and networking. However, this increased reliance has, in some cases, resulted in problematic or compulsive use that disrupts daily life and contributes to a range of negative consequences. Across all ages, research has shown that problematic social media use is linked to higher rates of depression, anxiety, and psychological distress (Hussain & Griffiths, 2018; Keles et al., 2019; Kennard et al., 2025; Lopes et al., 2022; Memon et al., 2018) which are risk factors for suicidality. The systematic review by Sedgwick et al. (2019) demonstrates that young people who engage in heavy or problematic social media or internet use are more likely to report suicidal thoughts and suicide attempts compared to their peers, with adjusted odds ratios for suicide attempts ranging from 1.03 to 5.10 across several large studies. This association remains even after accounting for confounding factors like cyberbullying and sleep disturbances, though these factors can reduce the strength of the relationship. In terms of substance abuse, data from the HBSC were analysed to find that adolescents with problematic SMU were more than twice as likely to misuse cannabis and more than three times as likely to smoke cigarettes as compared to peers with non-problematic use (Boniel-Nissim et al., 2022).

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 and education), 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.

In recent years, Malta has undergone rapid demographic and social transformation, evolving from a traditionally conservative society into a more liberal, multicultural nation due to strong economic growth and significant net migration, particularly among working-age adults from both EU and non-EU countries. This influx has offset challenges related to an ageing population and low fertility, but has also placed considerable pressure on Malta's health, mental health, and social support systems. While foreign labour has supported economic expansion and addressed skill shortages, it has also contributed to wage pressures, job competition, and concerns over migrant workers' rights and working conditions. Despite policy efforts such as the national Anti-Racism Strategy, evidence of discrimination and xenophobia persists. Broader social changes, including urbanisation, shifting

social norms, increased female workforce participation, rising property prices, and declining family-based care, have further strained traditional support structures and heightened the risk of social exclusion for vulnerable groups. The mental health sector faces ongoing challenges, including staff shortages and fragmented services, though recent reforms have aimed to strengthen community-based care. These demographic, economic, and social shifts have increased psychosocial stressors and the demand for mental health support, placing both migrants and the wider population at greater risk for mental health difficulties and suicide.

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).

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. Additionally, statistics from the Foundation for Social Welfare Services' (FSWS) national support line, 179, reveal a substantial increase in calls related to loneliness over a six-year period, rising from 7% of total calls in 2018 (n = 648) to 35% in 2024 (n = 3,902). 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.

The 2024 ESPAD data for Malta reveals concerning trends in substance use among students aged 15 to 16 years (ESPAD Group, 2025). Approximately 11.5% of students reported using cannabis in their lifetime, with 9.04% indicating use within the past month. This represents a significant increase from the 4.7% reported in the previous ESPAD survey (2019), potentially reflecting the impact of recent cannabis legalisation. Additionally, 1.5% of students reported lifetime use of ecstasy, 1.33% reported lifetime use of cocaine, and 0.6% reported lifetime use of heroin. In addition, 64.5% of students reported having consumed alcohol at least once in the past 12 months, with nearly one in ten drinking on 20 or more occasions, suggesting ongoing early exposure to alcohol use among adolescents. Moreover, 37.1% of students reported drinking alcohol within the past 30 days, while 33.3% reported having experienced alcohol intoxication at least once in their lifetime, with the majority indicating only one to two such episodes. Notably, Malta also stands out in terms of gender differences in illicit drug use, with lifetime prevalence among girls exceeding that of boys by six percentage points (15% versus 9.3%), highlighting the need for gender-sensitive prevention efforts.

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).

The 2022 Health Behaviour in School-aged Children (HBSC) survey collected data from nearly 280,000 adolescents aged 11, 13, and 15 across 44 countries and regions in Europe, central Asia, and Canada (Boniel-Nissim et al., 2024). The results indicated that adolescents who were heavy but non-problematic users of social media and the internet reported stronger peer support and social connections. This aligns with earlier research showing that social media platforms can effectively promote mental health and prevent suicide by providing accessible peer-support communities, enhancing emotional wellbeing, building resilience, and supporting recovery (Naslund et al., 2016). Additionally, structured digital campaigns have proven successful in increasing mental health literacy, reducing stigma, and encouraging help-seeking behaviour among young people (Sontag-Padilla et al., 2018). However, the 2022 HBSC survey demonstrated that problematic social media use (SMU) among adolescents rose to 11% in 2022, from 7% in 2018. Malta reported the second highest prevalence of problematic SMU at 18%, just behind Romania at 22%, while the overall HBSC average was 11%. The prevalence of problematic SMU is significantly higher among 11-year-olds girls in only 6 countries and regions, including Malta. Furthermore, Malta had the highest proportion of adolescents at risk for problematic gaming, at 19%. Digital behaviour patterns among young people were closely linked to how they accessed, engaged with, and placed trust in support systems at home, with friends and peers, in school, and within their communities. The report *The Wellbeing of Children and Young People in Malta* by Cefai et al. (2024) highlights the high SMU among this population, particularly adolescents aged 11 to 15, warns of the risks of problematic SMU, and advocates in favour of physical exercise, sports, and nature-based activities for their wellbeing.

In addition to addressing these behavioural trends 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 *The 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.

The PISA 2022 assessment for Malta included a highly representative sample of 3,127 15-year-old students across 46 local schools. The assessment highlighted several concerns regarding students' safety, sense of belonging, emotional wellbeing, and bullying, compared to OECD averages. Only 64% of Maltese students feel a sense of belonging at school, notably below the OECD average of 75%, and 26% report feeling like outsiders – a figure significantly higher than the OECD's 17% (OECD, 2023). Emotional wellbeing has declined, with 24% of students reporting low life satisfaction, up from 20% in 2018 and exceeding the OECD average of 18% in 2022. Safety perceptions reveal that 9% of students feel unsafe in classrooms (OECD average: 7%), while 7% feel unsafe traveling to school (OECD average: 8%). Bullying remains prevalent, with 29% of boys and 24% of girls experiencing

bullying at least monthly, surpassing the OECD averages of 21% and 20%, respectively, although incidents of spreading rumours have decreased from 15% to 9% since 2018 (OECD, 2023). These findings underscore the need for targeted policy interventions aimed at fostering inclusive school environments, enhancing student wellbeing, and reducing bullying, in line with international benchmarks.

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], 2025; Eurostat, 2023) (Fig. 1 and Table 1). 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. The confirmed SMR for suicide in Malta in 2023 was 5.39 deaths per 100,000 population, while the provisional SMR for 2024 is 4.31 deaths per 100,000 population (DHIR, 2025). This provisional figure for 2024 may increase slightly following final analysis.

The SMR in Malta is invariably higher for males than females, and this is consistent with other European Union countries (DHIR, 2025; Eurostat, 2023). Table 1 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 2. This is the only information that is categorised by residents and non-residents.

The latest suicide mortality data for Malta indicate that the highest suicide rates in 2023 were observed among males aged 45-64, with 13.3 deaths per 100,000 population, and

Figure 1
Trends in Standardised Mortality Rate per 100,000 population in Malta vs EU average by year, due to Intentional Self-harm (DHIR 2025; Eurostat 2023).

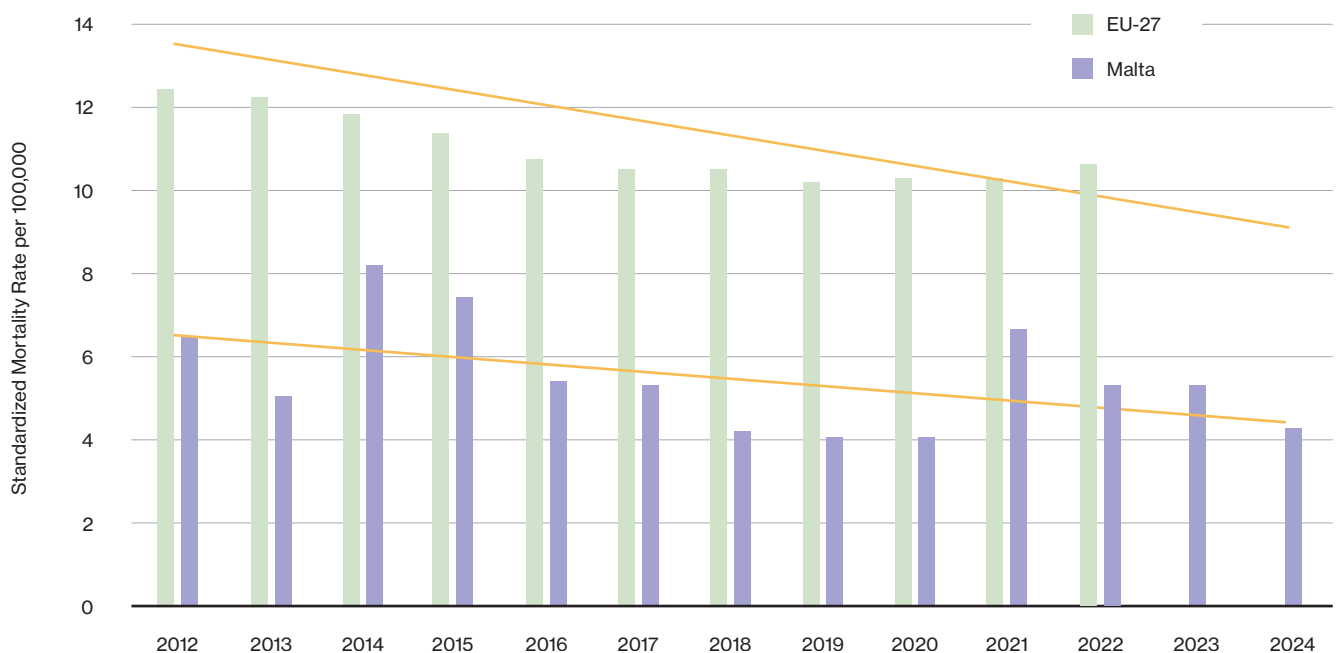


Table 1

Standardised mortality rate in Malta vs EU average, per 100,000 by year and sex due to Intentional Self-harm (DHIR 2025; Eurostat 2023).

Total	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
EU-27	12.38	12.25	11.81	11.39	10.75	10.49	10.49	10.19	10.26	10.24	10.58		
Malta	6.40	5.02	8.15	7.39	5.33	5.23	4.11	3.95	3.98	6.59	5.21	5.39	4.31
Males													
EU-27	20.69	20.28	19.52	18.75	17.76	17.21	17.2	16.76	16.86	16.75	17.22		
Malta	11.13	9.63	16.01	11.43	8.92	8.55	7.33	7.2	5.06	9.09	9.15	9.23	6.67
Females													
EU-27	5.22	5.30	5.15	5.03	4.66	4.65	4.66	4.43	4.49	4.55	4.77		
Malta	2.87	0.40	2.36	3.20	1.69	1.97	0.85	0.38	2.72	3.88	1.50	1.15	1.69

N.B. SMR statistics for Malta apply exclusively to residents and do not include data for non-residents, in accordance with standard statistical methodology.

Figure 2

Trends in the Standardised Mortality Rate per 100,000 population in Malta, due to Intentional Self-harm by year and sex (DHIR, 2025).

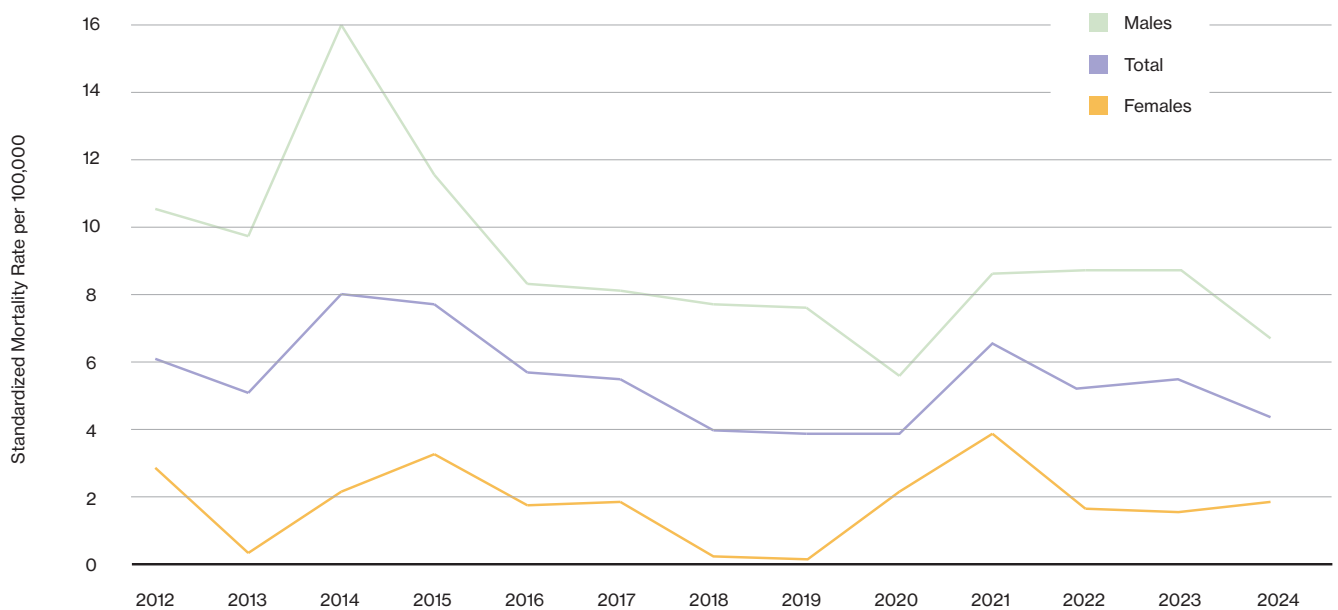


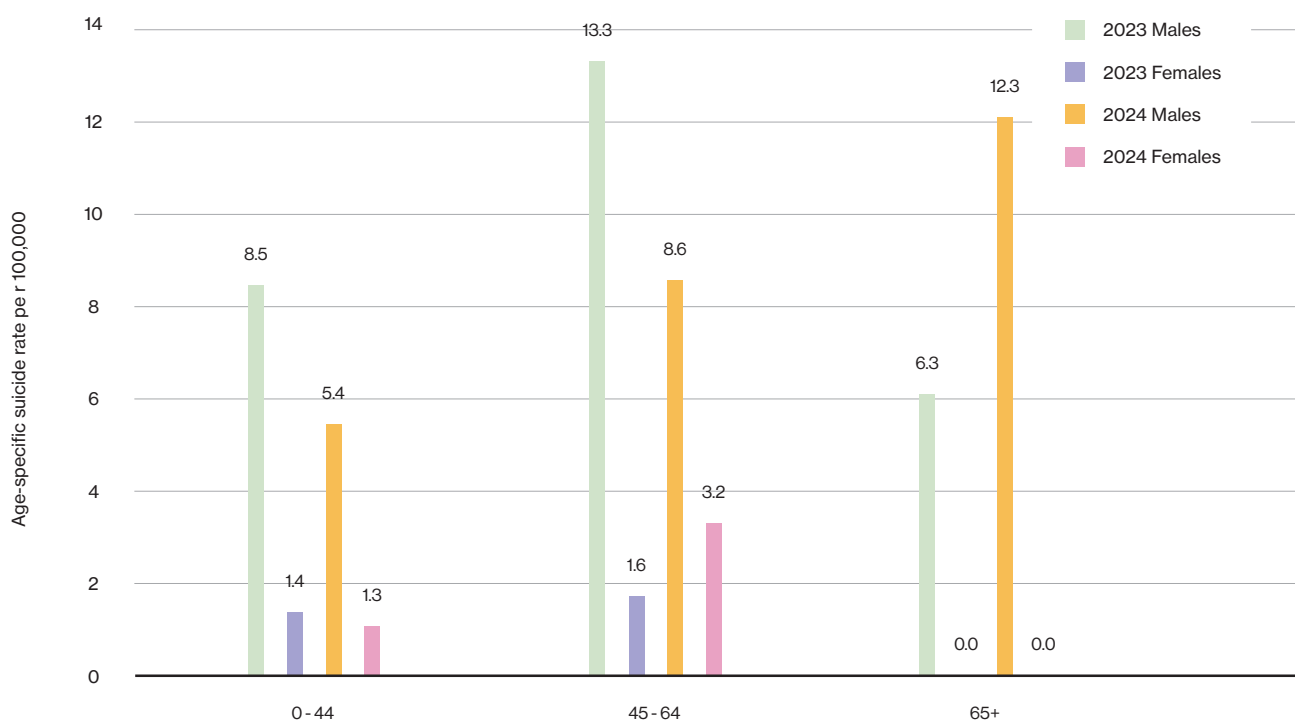
Table 2

Number of deaths in residents and non-residents by sex, due to suicide in Malta (DHIR, 2025).

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	3	1	4
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	1	0	1
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	27	3	30	2023	1	0	1
2024	22	4	26	2024	5	1	6

Figure 3

Age-specific suicide rate per 100,000 population in 2023 (confirmed) and 2024 (provisional), by age group and sex (DHIR, 2025)



in 2024 among males aged 65 and older, with 12.3 deaths per 100,000 population. Suicide mortality rates among females remain considerably lower; however, a slight increase has been noted in the 45-64 age group over the past three years, with rates of 1.6 deaths per 100,000 in 2022 and 2023, rising to 3.2 deaths per 100,000 in 2024. It is important to note that this observation does not currently constitute a definitive trend.

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).

Risk Factors for Suicidal Behaviour

Data on the number of hospitalisation due to self-harm (Table 3) and data on the most common methods of self-harm (Table 4) 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 and 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%).

Table 3

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

	Age Group (years)						Total
	0-19	20-39	40-59	60-79	≥80	Unspecified	
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 4

Most common methods of self-harm for year 2020, with or without suicidal intent, by age group and sex (NHIS, 2023).

	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

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.



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

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

Building capacity and fostering innovation to improve the performance of the National Mental Health Services.

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.

In the year 2024, the proportion of involuntary admissions to Mount Carmel Hospital (MCH) (n=996) to the number of total MCH admissions (n=2336) was 0.43. The proportion of male admissions (n=1514) to the number of total MCH admissions (n=2336) was 0.65. The proportion of involuntary male admissions (n=642) to the number of total involuntary admissions (n=996) was 0.64. The ratio of male to female psychiatric admissions at Gozo General Hospital (GGH) is approximately the same as that observed in Malta at 3:2.

In 2024, the proportion of involuntary admissions to the Gozo Short Stay Psychiatric Unit (SSPU) (n=52) to the number of total SSPU admissions (n=165) was 0.32. The proportion of male admissions (n=116) to the number of total SSPU admissions (n=165) was 0.70. The proportion of involuntary male admissions (n=31) to the number of total involuntary admissions (n=52) was 0.60. In the year 2024, there were 117 admissions to the Long Stay Psychiatric Unit (LSPU) for extended psychiatric care. In total, 282 inpatients were hospitalised at the two psychiatric units within Gozo General Hospital in the year 2024.

In 2024, the Crisis Resolution and Home Treatment (CRHT) team received 409 referrals, with 375 individuals receiving intensive community-based psychiatric care from the team, representing a 16% increase compared to 2023. The average age of service users was 35.75 years (SD = 13.74), with females comprising 53% of the total caseload. The majority of referrals originated from the Central (36%) and Southern (34%) regions of Malta, while fewer referrals came from the Northern region. Approximately one third (32%) of service users were referred due to suicidal ideation, and 16% following a suicide attempt. Other reasons for referral included depression (16%), anxiety and stress (16%), acute mental distress including distress arising from relational difficulties (11%), and severe mental disorders such as psychosis and mania (10%). Figure 6 presents the diagnostic distribution for CRHT service users in 2024.

The staff at the Young People's Unit (YPU) at Mount Carmel Hospital provided a total of 127 emergency consultations to minors presenting to the Accident and Emergency (A&E) Department within Mater Dei Hospital through Child and Adolescent Psychiatric Emergency Services (CAPES). They also provided intensive community-based psychiatric care to 187 minors through Crisis Intervention and Home Treatment (CIHT). Additionally, 120 minors required inpatient admission to the YPU at Mount Carmel Hospital. In 2024, female minors more frequently accessed psychiatric services compared to their male counterparts, comprising the majority of cases at CAPES (53.5%), CIHT (55.1%), and YPU (58.3%).

Data from the 1579 National Mental Health Helpline reveals that 9,830 calls were received in the year 2024. Of the total calls, only 3.5% (n=343) were related to suicide, with Figure 7 illustrating the monthly distribution of these suicide-related calls. Notable peaks in suicide-related calls occurred in April, May, and October, aligning with seasonal changes that have been widely linked to increased suicidality in research (Christodoulou et al., 2012; Galvão et al., 2018). Notably, female callers

consistently outnumbered male callers. Collection of more detailed variables could help identify areas of concern or opportunities for improvement, thereby guiding future decision-making processes regarding resource allocation and service enhancements. It is also important to highlight the Foundation for Social Welfare Services' (FSWS) national support line, 179, which has been in operation for the past 29 years and which also receives redirected calls from the harmonised EU emotional helpline, 116 123. In 2023 and 2024, the support line recorded 79 and 58 calls related to self-injurious behaviours including suicide, representing 0.7% and 0.5% of total calls respectively.

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, Article 3 (1) (h)). 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 a history of suicidal behaviour and those bereaved by suicide have been consulted for the writing of this strategy.

Figure 6
Distribution of diagnoses for CRHT service users in 2024.

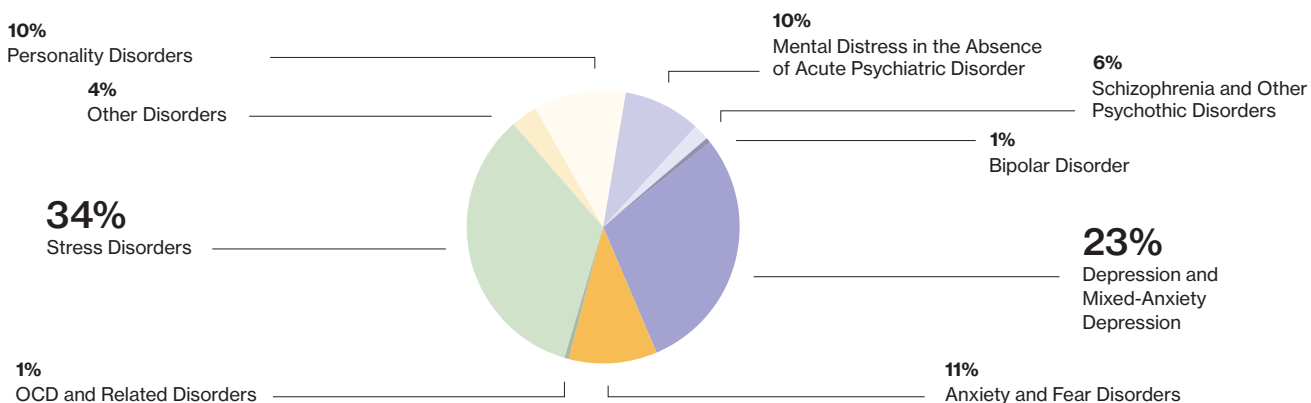
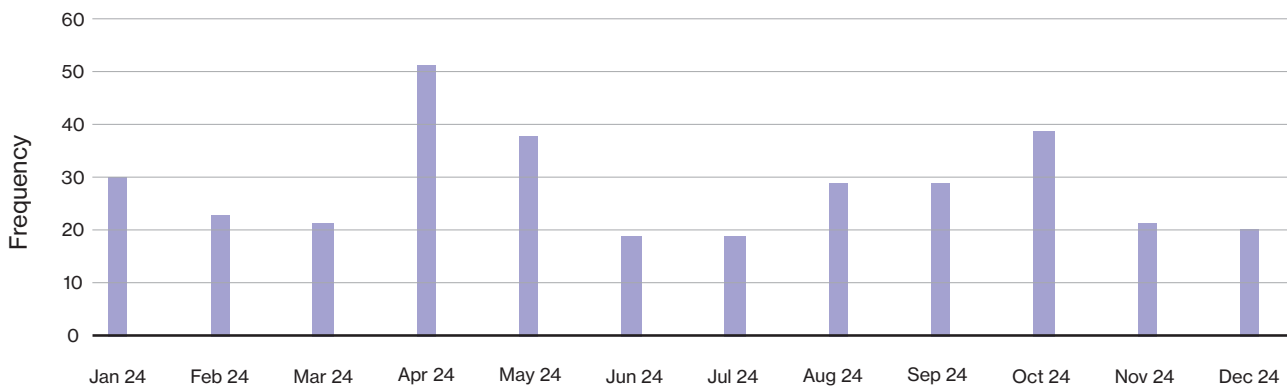


Figure 7
Distribution of suicide-related calls received by the 1579 National Mental Health Helpline in 2024.



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, Article 3(1)(h)).

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 a hospital-based outpatients' clinic on the grounds of Mount Carmel Hospital, Centro Tommaso Chetcuti (CTC), and 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 Saħntek [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

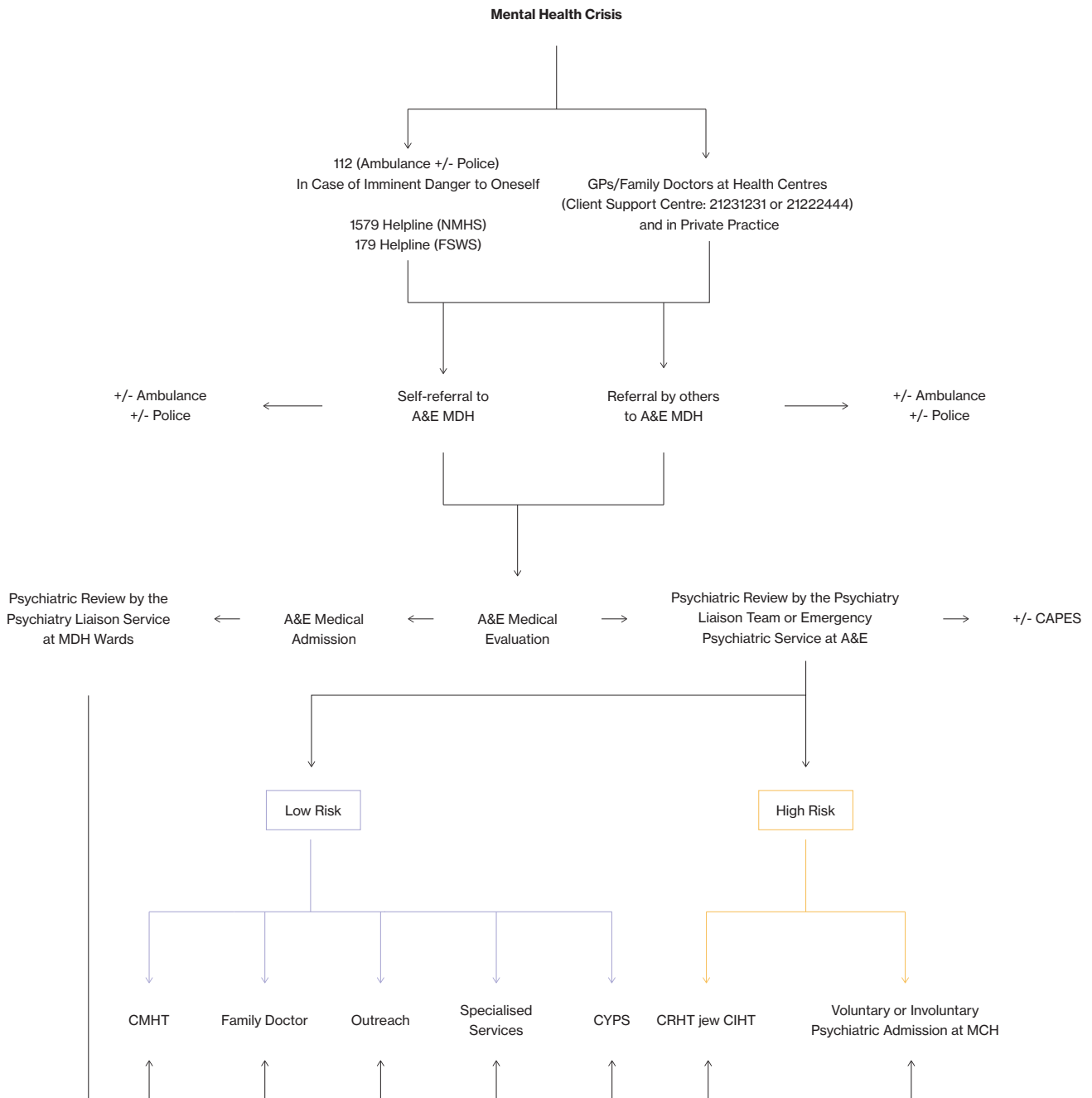
The national NMHS offer a 24/7 Emergency Psychiatric Service (EPS), which is based in the Accident & Emergency (A&E) Department within MDH. Through this service, on-call psychiatrists and/or senior psychiatry trainee doctors, offer acute mental health assessment and treatment to persons who present to 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.



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 persons with a history of suicidal behaviour and those bereaved by suicide 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

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.

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.

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.

Key Performance Indicators

01

Strategy review.

02

Number of meetings held by the Strategy Committee and the Multistakeholder Committee.

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.

Key Performance Indicators

01

Number of mental health professionals working in the inpatient setting successfully completing training.

02

Number of gatekeepers successfully completing training.

03

Feedback from post training satisfaction surveys.

04

Number of meetings with gatekeepers.

05

Number of protocols that are established.

06

Number of GPs/GP trainees/Family Doctors attending training provided by specialists in psychiatry.

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 Department 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 and 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 and Home Treatment (CRHT) team in December 2021.

02

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

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.

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. Therefore, acute admissions should in future be in centres of care that cater for both physical and mental health care.

Planned Actions

01

Provide ongoing training to mental health professionals working at all Emergency and Stabilisation services, 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 Psychiatric Centre (APC) within Mater Dei Hospital to provide acute and inpatient mental health care in a destigmatised, dignified, and therapeutic environment. Accordingly, patients requiring such care should be admitted to healthcare facilities that provide both physical and mental health care.

04

Facilitate structured and ongoing collaboration with psychiatrists, psychiatric trainees, and nursing staff within the Psychiatry Liaison Team and Emergency Psychiatric Service (EPS) at the A&E Department. This partnership aims to systematically integrate their expertise and frontline insights to address challenges and enhance service delivery for individuals presenting with mental health crises, including those experiencing suicidal crises.

05

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

Key Performance Indicators

01

Number of interventions by 1579 personnel.

02

Number of interventions by CRHT and CIHT.

03

Hospitalisation rate of service users seen by CRHT, CIHT and CAPES.

04

Number of mental health professionals staffing the CRHT team.

05

New protocols devised by the CRHT team with the scope of service expansion.

06

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

07

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

08

Development of the Acute Psychiatric Centre and the securement of a private area for mental health assessment within the A&E Department.

09

Development of a fast-track psychology referral protocol for at-risk individuals.

Strategic Goal 3

Sufficient psychosocial support and care structures are provided to high-risk 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

02

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

04

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

01

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

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.

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).

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 mental health professionals working within NMHS.

12

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

13

To introduce newer generation antidepressant medications with more favourable side-effect profiles (such as Sertraline and Escitalopram, among others) 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 translation and interpretation sessions offered for NMHS service users.

02

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

03

Number of re-admissions to a psychiatric facility within 2 months of transition to community NMHS.

04

Number of training sessions provided to gatekeepers to enable early detection and intervention.

05

Establishment of a referral or care pathway for postvention services.

06

National self-reported loneliness ratings.

07

Number of LGBTIQ+ individuals accessing mental health support.

08

Number of individuals with substance use disorders accessing mental health support.

09

Number of attendees to resilience courses organised by HPDP.

10

Number of mental health professionals attending cultural competence training.

11

Number of healthcare professionals attending training on breaking bad news.

12

New antidepressants introduced on the governmental formulary.

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.

Planned Actions

01

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

02

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

03

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

04

Regular police patrols at hotspots.

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 posters placed at hotspots.

02

Number of phonebooths placed at hotspots.

03

Number of preventative fences and/or barriers erected.

04

Number of police patrols at hotspots.

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 Self-Injury 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 'Hu Hsieb' [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, yearly on 10th September. 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.

02

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

Planned Actions

02

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

04

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

01

Establish a protocol to notify media houses that do not adhere to shared guidelines on reporting suicidal behaviour, facilitating a review of their narrative.

03

Upgrade the digital infrastructure to provide clear guidance on appropriate actions during a mental health crisis and prominently feature information on available National Mental Health Services, self-help resources, and resilience training.

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

02

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

04

Number of digital mental health awareness campaigns, with media reach.

01

The establishment of a protocol for media houses who do not adhere to the shared guidelines on reporting suicidal behaviour.

03

Establishment of user-friendly digital infrastructure for NMHS.

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.

Problematic social media use among adolescents has been shown to negatively affect their wellbeing and may increase the risk of suicidal behaviour. In response, schools in Malta have implemented a range of measures, including clear policies on acceptable internet and device use, curriculum-based education on healthy and responsible social media habits, training for educators,

and information sessions for parents-primarily through the BeSmartOnline! initiative, which promotes safe and balanced internet use among children, parents, and educators. In this context, the strategy outlines two key priorities: enhancing the resources and environments that support young people's health and wellbeing and fostering open dialogue about digital wellbeing to reduce stigma, raise awareness, and improve digital literacy.

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.

02

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

03

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

04

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

Planned Actions

01

Improve adolescents' access to confidential and non-judgmental mental health services that address issues arising from problematic digital technology use.

02

Promote open dialogue about digital wellbeing across families, schools, and communities by implementing targeted awareness-raising and educational campaigns.

03

Offer specialised training for healthcare professionals to equip them with the skills needed to deliver effective and inclusive interventions for individuals with problematic digital technology use.

04

Formalise and endorse the safety plan document that is to be used within NMHS and encourage its use within acute settings, and any other clinical setting where it is deemed beneficial to service-users.

05

Offer in-house training on safety planning to professionals working within the acute NMHS.

06

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

07

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.

08

Promote the nationwide project to equip individuals with Mental Health First Aid, available through all local councils in Malta and Gozo, in collaboration with the Parliamentary Secretariat for Local Government.

09

Collaborate with NGOs, local councils, and other community actors to offer outreach talks on mental health literacy and awareness.

Key Performance Indicators

01

Number of healthcare professionals successfully completing training for problematic digital technology use.

02

Endorsement of a formal safety plan document for NMHS.

03

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

04

Number of mental health promotion and awareness-raising campaigns.

05

Engagement and reach metrics for online mental health campaigns.

06

Number of meetings with primary care services.

07

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

08

Number of individuals completing the Mental Health First Aid course.

09

Number of community outreach talks conducted.

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 and society-focused 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.

Currently, a hybrid system combining handwritten notes and digital records is in use within the National Mental Health Services. However, there is an urgent need to strengthen and streamline these systems by transitioning to a paperless and interoperable platform. In the coming years, the establishment of the Electronic Medical Records (EMR) system across all National Healthcare Services in Malta and Gozo will improve data accuracy, accessibility, and timeliness, enabling more effective monitoring, analysis, and evidence-based decision-making to support suicide prevention efforts.

Implemented Actions

01

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

Planned Actions

01

In harmony with other key stakeholders, NMHS will take a leading role in coordinating and implementing the Electronic Medical Records (EMR) system across all National Healthcare Services in Malta and Gozo. This collaboration will ensure that NMHS, along with other national health entities, is at the forefront of the transition from paper-based records to a unified, paperless, and secure digital health record system.

02

All Tickets of Referral (TORs) from community healthcare providers will be submitted directly through the myHealth patient-doctor portal and processed electronically within the NMHS. Furthermore, internal TORs referred to from other National Healthcare Services will be managed through the new EMR system. This will ensure that all referrals are handled digitally, enhancing efficiency, accuracy, and accessibility of TORs across NMHS.

Key Performance Indicators

01

Number of collaborative meetings in relation to the development of the Electronic Medical Records (EMR) system.

02

Annual analysis of the actions and KPIs related to the National Suicide Prevention Strategy.

03

Digitalisation of tickets of referrals to all applicable NMHS.

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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.

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.

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.

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.

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.

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.

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.

Inpatient Services

Acute Psychiatry

Admission Wards, MCH & Short Stay Ward, GGH

Provided by MDT

Client Group

Persons ≥ 18 yrs 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 & Long Stay Ward, GGH

Provided by MDT

Client Group

Persons ≥ 18 yrs 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 ≥ 65 yrs 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 < 18 yrs 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

Psychiatry Liaison Service

MDH

Provided by Psychiatrists,
Psychiatric Nurses, Social Worker

Old Age Psychiatry

SVPR KGH

Provided by incl. Geriatrician

Eating Disorders Inpatient Service

Fondazzjoni Kenn Għal Saħħtek

Provided by MDT

Gozo General Hospital (GGH)

Short Stay Psychiatric Unit, GGH

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)

Client Group

Inpatients with psychiatric conditions within MDH

Referred by

Doctors at MDH

Client Group

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

Referred by

Psychiatrists, PLS, Geriatricians, Doctors at SVPR & KGH

Client Group

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

Referred by

GPs, Psychiatrists

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 ≥ 18 yrs 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 and Home Treatment (CRHT)

Based at CRHT Clinic I/o MCH; service is provided within the community setting

Provided by Psychiatrists, Nurses

Client Group

Persons ≥ 18 yrs 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 < 18 yrs 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 < 18 yrs 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

Ġentru Tommaso Chetcuti (ĠTC), MCH

Provided by MDT

Client Group

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

Referred by

Psychiatrists

Community Mental Health Teams (CMHTs)

Mental Health Clinics at Mtarfa, Qawra, Mosta, Floriana, Cospicua, Qormi & Paola

Provided by MDT

Client Group

Persons ≥ 18 yrs with severe or persistent mental health problems, who require ongoing treatment and support, and who may be cared for in a community setting

Referred by

Psychiatrists, CRHT, EPS, PLS, GPs

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 ≥ 18 yrs with a chronic or complex mental health disorder, 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 ≥ 18 yrs 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 & Staff 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

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SOS Malta

St Jeanne Antide Foundation

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Malta Psychology Profession Board (MPPB)

Ms Jo Christine Scicluna

Malta Gay Rights Movement (MGRM)

Drachma

Relationships are Forever Foundation

Richmond Foundation

Malta Local Councils Association

Experts by Experience

Anonymous

Suicide attempt survivor

Individuals with lived experience of suicidal thoughts and intentions

Person bereaved by suicide

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.

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 healthcare professionals frequently working with persons in suicidal crisis (e.g. Emergency and Stabilisation Services staff, Ambulance crew, and A&E staff) and provide the appropriate training.

Implementation by

NSPS Committee

Measure

Training needs analysis report; % healthcare professionals successfully completing training

Target Value

1 report; 80%

Identify key gatekeepers who would benefit from training on early detection and intervention, and suicide risk assessment and management, and provide the identified gatekeepers with training.

Implementation by

NMHS, NSPS Committee

Measure

Number of identified gatekeepers; Number of meetings with gatekeepers; % gatekeepers successfully completing training

Target Value

2 meetings per year; 80%

Specialists in psychiatry provide training to GPs/ Family Doctors in private and public practice focused on the management of common mental illnesses in the community and suicidal risk.

Implementation by

NMHS, NSPS Committee

Measure

% of GPs/Family Doctors successfully completing training.

Target Value

80%

Support gatekeepers in establishing protocols at the workplace and/or 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

As required

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

1 area

A newly built Acute Psychiatric Centre 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 facility

To gradually increase the complement of professionals working in Emergency and Stabilisation mental health services, most prominently within the CRHT team.

Implementation by

NMHS, NSPS Committee

Measure

Number of professionals working in Emergency and Stabilisation mental health services

Target Value

As required

Implement the inpatient to community NMHS 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 NMHS

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 death.

Implementation by

NMHS, Multistakeholder Committee

Measure

Postvention services ongoing

Target Value

1 referral pathway SOP

Develop a fast-track psychology referral protocol within NMHS for individuals at high risk of suicide or those who have recently attempted suicide.

Implementation by

NMHS

Measure

Protocol established

Target Value

1 protocol

Offer cultural competence training to mental health professionals working within NMHS.

Implementation by
NMHS

Measure
% of mental health professionals successfully completing training

Target Value
80%

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

Implementation by
NSPS Committee

Measure
% of eligible healthcare professionals successfully completing training

Target Value
50%

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
NSPS Committee, Multistakeholder Committee

Measure
Posters and infographics placed

Target Value
2 posters per hotspot

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 and operational

Target Value
1 phonebooth per hotspot

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

Target Value

As required

Regular police patrols at suicide hotspots.

Implementation by

Malta Police Force

Measure

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

Target Value

Frequency to be determined, contingent on resource availability

Establish a protocol to notify media houses that do not adhere to shared guidelines on reporting suicidal behaviour, facilitating a review of their narrative.

Implementation by

NSPS Committee, Multistakeholder Committee

Measure

Protocol established; Number of meetings/communications with media

Target Value

1 protocol; Meetings/communications as required

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

Implementation by

NSPS Committee, Education Department

Measure

Number of meetings with the Education Department; Resilience training framework developed

Target Value

Meetings as required; 1 resilience training framework developed

Prevention and Health Promotion Activities

Upgrade the digital infrastructure to provide clear guidance on appropriate actions during a mental health crisis and prominently feature information on available National Mental Health Services, self-help resources, and resilience training.

Implementation by

NMHS

Measure

Digital infrastructure updated

Target Value

1 user-friendly website

Offer in-house training on safety planning for acute 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 endorsed document

Mental health promotion and awareness-raising activities and/or campaigns.

Implementation by

NSPS Committee, HPDP, Education Department

Measure

Number of activities and/or campaigns; Number of collaborations with the HPDP Directorate

Target Value

6 activities and/or campaigns per year

Offer specialised training for healthcare providers to equip them with the skills needed to deliver effective and inclusive interventions for individuals with problematic digital technology use.

Implementation by

NSPS Committee, NMHS

Measure

Trained child & adolescent mental health professionals

Target Value

2-4

Quality Assurance and Expertise

Develop a digital health record in line with the new Ministry-wide Electronic Medical Records (EMR) system.

Implementation by

MHA

Measure

Improved data accuracy and availability

Target Value

1 EMR system

Tickets of referral to all applicable NMHS services are made electronic and accessible.

Implementation by

MHA

Measure

Tickets of referral are digitalised

Target Value

Tickets of referral as required

