Country Profile Malta

Suicide and Suicide Prevention: Key Facts and National Priorities

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Introduction

The EU-Co-funded "Joint Action on Implementation of Best Practices in the area of Mental Health", short **JA ImpleMENTAL** has a duration of 3 years, lasting from October 2021 to September 2024. Detailed information can be found at the project's website JA ImpleMENTAL ja-implemental.eu. It aims to promote and improve mental health structures, services, capacity and outcomes in participating countries in 2 specific areas:

- mental health reform (promoting community health services) and
- suicide prevention.

Two national best practices - mental health reform in Belgium and the Austrian suicide prevention programme SUPRA - serve as best practice examples. Selected components of these should be prioritised and implemented over the course of the JA in 14 i.e. 17 participating EU-countries. JA ImpleMENTAL comprises 6 Work Packages (WPs), 4 horizontal WPS and one for each best practice. **WP6 on suicide prevention** aims to support improvement in knowledge and quality of suicide prevention services. Defined elements of SUPRA should be transferred and pilot implemented at national/regional level, suicide prevention strategies in participating countries developed i.e. revised.

The present country profile is one of the major deliverables of the JA, presenting national priorities for suicide prevention embedded in contextually relevant facts. It summarizes results of the national Situation- and Needs Assessment (SANA), lists lessons learned, recommendations and prioritized measures for suicide prevention. It includes challenges and opportunities as well as outlining next steps necessary to scale-up i.e. promote national/regional suicide prevention activities. The country profile is a basis for strategy formulation, for decision-making and a declaration of commitment to suicide prevention.

1 Context

1.1 Country, Health and Social System

Malta is an island county in the Mediterranean Sea. Resident population in Malta stood at 516,100 (1), more than doubling over a century, and growing by more than 100,000 over the past 10 years. Malta remains the most densely populated country in the EU with 1,649 residents per square kilometre.

Table 1: Population structure: 2021, expressed as number of persons, by age and sex (1)

	Sex		
Age group	Male	Female	**Total**
<18	42484	39646	82130
18 - 64	179726	156826	336552
65+	44729	52689	97418
Total	**266939**	**249161**	**516100**

Healthy life years at birth in 2020 in Malta for women was 70.7 years whilst for men was 70.2 years. (1). A total of 19.9% of the population is at risk of poverty and social exclusion (2). Income inequality, expressed as the Gini coefficient, is 30.3 (3), and total healthcare expenditure relative to GDP is 8.95 % (10).

Malta's National Health Service (NHS) is predominantly financed through general taxation, and provides almost universal coverage to all residents. The Ministry for Health is responsible for governance, regulation, and financing of the health system, and is the main provider of public health services (11).

1.2 Mental Health System

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

Actions withing the strategy are grouped under four thematic clusters:

- Promoting mental health and wellbeing by addressing the wider determinants of health
- Transforming the framework within which mental health services are delivered
- Supporting all persons with mental disorders and their families

- Building capacity and fostering innovation to improve the performance of our mental health services.

The implementation of the mental health strategy has been entrusted to the Senior Management Team of the Mental Health Services reporting regularly directly to the Chief Medical Officer on progress registered. Yearly plans and milestones are to be agreed in line with approved budgets and monthly monitoring of these initiatives will take place.

The Maltese government has allocated 65 million Euro to Mental health services as an estimate for the financial budget for 2023. There is no specific budget allocated to the implementation of the strategy.

Mental Health Services have a ring-fenced budget amounting to 61,275,000 in 2022, this amounts to 6.83% of the national health budget (2022).

The majority of persons with severe mental health conditions, and also some with non-severe mental health conditions, receive income, housing, employment, education, social care as well as legal support from the government. There is additional assistance from NGOs in the case of housing and social support.

The share of people reporting unmet mental health care needs due to financial reasons stood at 2.1% in 2014 (13) and 1.6% in 2019.

The proportion of involuntary admissions to MH hospitals (575) to number of total admissions (1819) is 0.31. The proportion of involuntary admissions to psychiatric wards of general hospitals (25) to number of total admissions (118) is 0.21 (4).

Follow-up care (the share of patients, who receive out-patient visits appointments within one month from discharge) of people with mental health conditions discharged from hospital is calculated to be more than 75%. There are currently seven (7) community-based mental health outpatient facilities in Malta (5).

Table 2: Illustrates the facilities, number of beds and of hospital admissions related to mental health, for 2020, which is the latest available year (5)

Indicator at national level		Number	Rate per 100.000 adult/minor population
Mental health hospitals (3,5)	Facilities	1	0.46
	Beds	268	61.76
	Admissions	1819	419.15
Psychiatric wards/units in general hospitals (4)	Wards/units	2	0.46
	Beds	52	11.98
	Admissions	118	27.19
Mental health inpatient facilities specifically for children and adolescents (4)	Facilities	1	1.22
	Beds	10	12.18
	Admissions	85	103.49

2 Suicide and Suicide Prevention

2.1 Situation Analysis (SA)

Data for suicide method by year, gender and age group together is not available. Figures for the suicide rate extracted from the National Mortality register are found below.

Figure 1: Suicide rate: 2019, by age groups and sex (7)

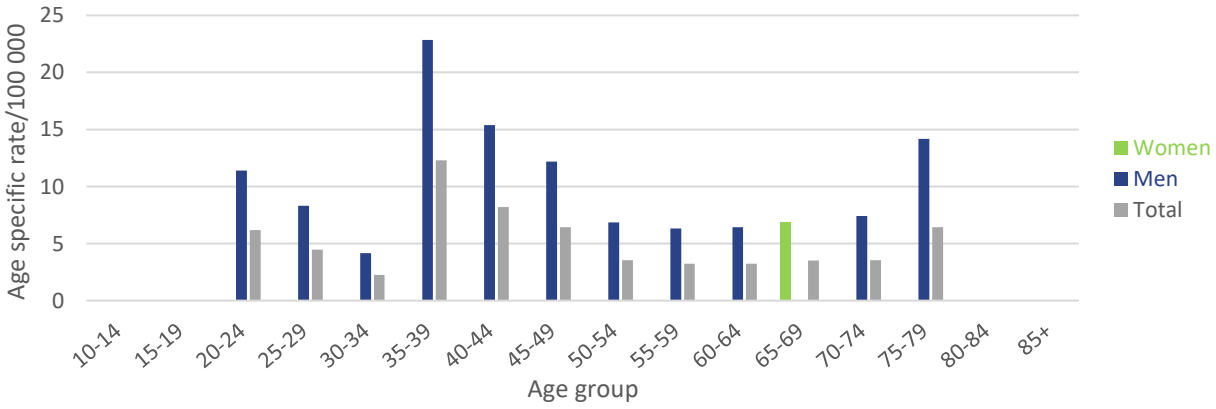
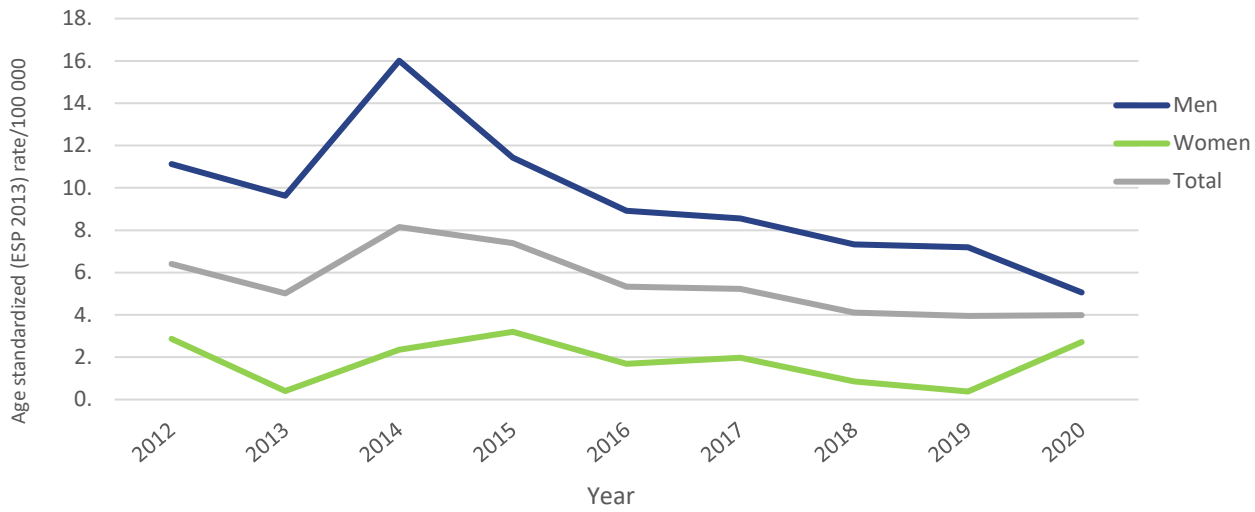


Figure 2: Suicide deaths trend 2012-2019, by sex (7)



It is difficult to comment about trends, given that numbers are small and also considering the challenges in reporting and case confirmation. There seems to have been a peak in cases in 2014 with a gradual decline over the past years.

Malta does not publish a regular annual report, including trends on suicide mortality.

Figures from the National Mortality register (2017-2021) show that the commonest means of suicide are Hanging (n=81), jumping from a high place (n=20), overdosing (n=9), and firearm discharge, (n=6), in decreasing order across all age groups.

Findings from a local study by Renaud (2019) (8) reported the most common 3 methods by gender are as follows:

Males: 1) Hanging, strangulation or suffocation

2) Jumping from a high place

3) Firearm

Females: 1) Jumping from a high place

2) Hanging, strangulation or suffocation

3) Self-poisoning by medication

The relevant conclusions pertaining to this question from the study by Renaud (2019) (8) is that the mean and median ages were lowest (i.e., younger age groups) for self-poisoning by gases, and highest (i.e., older age groups) for drowning or submersion.

Box 1. Most common barriers people face when seeking psychosocial help

No information is available on the most common barriers people face when seeking psychosocial help in a biopsychosocial crisis.

Box 2. Groups most vulnerable to suicide.

The 5 groups who were the most at risk of suicide according to Renaud (2019) (8) are:

1) Gender: Males

2) Age: 30 to 49

3) Marital status: Single or separated

4)Employment status: Unemployed, pensioners or boarded out &/ Occupational status: Low

5) Residence: Southern Harbour region

Table 3: Hospitalization due to self-harm: year, by age group and sex for 2020 (NHIS 2023)(9)

	0-19		20-39		40-59		60-79		80+		Unspecified	Total
	N	rate	N	rate	N	rate	N	rate	N	rate		
Female	25		57		50		14		0			146
Male	46		70		34		12		6		2	170
Total	71		127		84		26		6		2	316

Data on the most common methods of self-harm with or without suicidal intent; by year, age group has been captured from the National Hospitals Information System (9). Codes obtained from ICD-10 Version 2019 in brackets.

Table 4: Most common methods of self-harm with or without a suicidal intent: for year 2020, by age group and sex (9)

Sex/Age	0-19	20-39	40-59	60-79	80+
Female	1. Poisoning (Y10) 2. Intentional self-poisoning (X61) 3. Unspecified means (X83)	1. Poisoning (Y10) 2. Intentional self-poisoning (X61) 3. Unspecified means (X83)	1. Intentional self-poisoning (X61) 2. Poisoning (Y10) 3. Unspecified means (X83)	1. Intentional self-poisoning (X61) 2. Intentional self-poisoning (X60) 3. Poisoning (Y10)	1. Intentional self-poisoning (X64) 2. Unspecified means (X83) 3. Intentional self-poisoning (X61)
Male	1. Intentional self-poisoning (X69) 2. Hanging (X70) 3. Unspecified means (X83)	1. Unspecified means (X83) 2. Intentional self-poisoning (X61) 3. Sharp object (X70)	1.intentional self-poisoning (X61) 2. Intentional self-poisoning (X64) 3. Hanging (X70)	1. Intentional self-poisoning (X61) 2. Unspecified means (X83) 3. Hanging (X70)	1. Intentional self-poisoning (X64) 2. Unspecified means (X83) 3. Intentional self-poisoning (X61)

Malta does not have a national suicide prevention strategy/ policy/ plan to date; yet this is being developed as part of the JA ImpleMENTAL.

The service of a nation-wide 24/7 hotline for crisis-intervention and suicide prevention is currently available. This helpline receives calls from persons in psychological distress and is not solely dedicated to persons at risk of suicide.

There is a nationwide psychiatric crisis service on a 24-hour basis located within the A&E Department of the National Acute General Hospital. Patients are assessed medically to rule out any underlying medical organic problem before they are admitted to the psychiatric hospital if admission is required. Alternatively, patients may be referred to the Crisis Resolution Home Treatment Team (CRHTT) where they are followed up for a period of 4 weeks or if the patient risk is low, they may be followed up at the Community Mental Health clinics. Standardised follow-up care for patients in crisis in the community falls under the remit of the Crisis Resolution Home Treatment Team (CRHTT) who are followed for a period of 4 weeks. The team also channel patients to the right services - e.g., in-patient psychological or community mental health services as the case may need.

There is no official training organized for gatekeepers in various settings such as the educational setting or for General Practitioners. There are no programmes that address the specific groups that are most vulnerable to suicide.

Nation-wide restriction of means is not currently in place. Collaboration with the media concerning media recommendations on the reporting of suicide had taken place when the Malta Association of Psychiatrists (MAP) had issued guidelines to the media on World Suicide Prevention Day 2021.

There is no inventory on current projects on suicide prevention.

2.2 Needs Assessment (NA)

The SWOT analysis was done through several discussions in collaboration with hospital management, different Health Care Professionals working within the Mental Health Sector and professionals that collaborate closely with mental health services providers. The SWOT analysis was conducted via using the guiding questions on strengths, weaknesses, opportunities and threats. Then, the previously collected needs were integrated and discussed.

Table 5: SWOT analysis

Strengths	Weaknesses
1. One MHS governed by a single body, working through a legal framework- the Mental Health Act (2012) 2. Guided by the patient- focused mental health act and the mental health strategy (currently being implemented). 3. A dedicated budget (6.42% of health budget) to mental health services. 4. Qualified and specialized health care professionals with opportunities for continuous professional development. 5. Universal coverage for those with statutory rights with several psychotropic drugs listed the government formulary that can be obtained free of charge. 6. Community Services are main stay of care. 7. The development of specialized services targeting persons along the lifespan. 8. Good and professional co-operation within the SUPRA advisory board with established partnerships with key stakeholders. 9. Established crisis intervention hotline. 10. Strong collaboration with NGOs. 11. Training to health care professionals on suicide prevention.	1. No suicide and self-harm registry and data not readily available. 2. No suicide annual report. 3. No postvention and gatekeeping services available. 4. No dedicated website. 5. Limited collaboration with the media and with the Health Promotion department. 6. Unmet needs of vulnerable and minority groups.
Opportunities	**Threats**
1. JA ImpleMENTAL (networking with international experts in the field, training provision) 2. Awareness raising on topics of suicide and self-harm. 3. Key stakeholders and members of advisory board are willing to collaborate. 4. Increasing awareness about mental health difficulties making it more likely for one to seek help.	1. Challenges in co-operation with different sectors such as the education department. 2. Stigmatisation of individuals with mental illness and especially for persons with history of suicidal behaviour. 3. Lack of funding for ear marked for suicide prevention and for provision of mental health care in general. 4. Threat of a policy cycle (e.g., losing a support of key stakeholders). 5. Challenges in recruitment and retention of health care professionals. 6. Lack of motivation for continued participation in suicide prevention efforts. 7. Changing societal norms and values.

3 Reflection on SANA results

The current situation shows that we have multiple strengths that will help us to reach our aim of having a National Suicide Prevention Strategy. These include one organisation governed by the same legal framework and policies, a highly competent workforce and adequate budget. There are established emergency services that need to be upscaled especially for persons at risk of suicide and their families. This may be facilitated fostering collaboration with other stakeholders.

During the completion of the SANA, it became apparent that data is either missing or not readily available. The presence of a dedicated Mental Health Information System, the establishing of a register and the writing of an annual mortality report would facilitate data management and would inform our policies and services are responsive to the needs of the population. Improving mental health literacy, and training of first liners would be critical in linking persons at risk to points of care. The helpline that operates on a 24 x 7 basis run by Mental Health Services, and the presence of psychiatrists round the clock at the Acute General Hospital go a long way in supporting persons at risk.

We believe that the strategy will provide the necessary guidance to improve our services and to work with other stakeholders to minimise the risk of suicide. As the WHO rightly state that suicides are preventable, and much can be done to prevent suicide at individual, community, and national levels.

Box 3.

Prioritized measures for implementation

The main outcomes of the discussion and of the results of the SWOT analysis by Mental Health Services, the National Advisory board and WP6 leads:

Overarching measure

- Drafting of a National Suicide Prevention Strategy

Strategic Area 1 Coordination & Organisation

- Drafting of a Suicide Prevention Strategy

Strategic Area 2 Support and Treatment

Gate keeer Training

- **Quick Win: Training of healthe care professionals**

Sufficient psychosocial supply and care structures are provided for risk groups

- **Quick win:** Helpline
- Scaling up of mental health services
- Building capacity of the mental health workforce and providing the necessary support to ensre quality service delivery
- Providing support to persons at risk of suicide or self-harm and their families

Strategic area 3: Awareness and Knowledge

- Promoting mental health literacy and wellbeing

Strategic Area 4: Quality Assurance-Expertise and Databases

- Establishing a dedicated Mental Health Information System
- Establishing a register and the writing of an annual report to facilitate data management and to inform our policies and services to ensure that they are responsive to the needs of the population

4 Next steps

Nationally/regionally agreed upon steps, commitment (include by whom these were defined, when, in which context) and also, if available, who is in charge of implementation within which timeframe.

Mental Health Services have taken note of the suggestions given by the stakeholders during a seminar that was carried out on the 2nd of May 2023 to present the Country Profile. Mental Health Services through their participation in ImpleMENTAL are committed to draft a National Suicide Prevention Strategy, in consultation with the main stakeholders. The strategy will be guided by a series of actions under the following clusters:

- Promoting mental health literacy and wellbeing
- Scaling up of mental health services
- Providing support to persons at risk of suicide or self harm and their families
- Building capacity of the mental health workforce and providing the necessary support to ensure quality service delivery
- Establishing a MHIS

5 References

(1) Eurostat (2021) https://ec.europa.eu/eurostat/databrowser/view/DEMO_PJAN__custom_2986693/default/table?lang=en accessed online [5th August 2022]

(2) Eurostat https://ec.europa.eu/eurostat/databrowser/view/hlth_silc_17/default/table?lang=en accessed online [5th August 2022]

(3) Eurostat https://ec.europa.eu/eurostat/databrowser/view/ilc_di12/default/table?lang=en accessed online [5th August 2022]

(4) Mental health services data, 2021

(5) Eurostat https://ec.europa.eu/eurostat/databrowser/view/sdg_01_10/default/table?lang=en accessed online [5th August 2022]

(6) Mental Health Atlas, Malta Country Profile, 2020

(7) Mortality Register Data, 2019

(8) Renaud, K. (2019). Suicide in the Maltese islands between 1995 and 2018 (Master's thesis, University of Malta).

(9) National Hospitals Information System, 2023

(10) Eurostat https://ec.europa.eu/eurostat/databrowser/view/tps00207/default/table?lang=en accessed online [5th August 2022]

(11) Malta Health System Information (2021) OECD, European Health Observatory.

(12) Eurostat 2021 https://ec.europa.eu/eurostat/databrowser/view/tps00207/default/table?lang=en accessed online [5th August 2022]

(13) Unmet needs fot health care (2020) https://www.oecd.org/health/health-systems/Unmet-Needs-for-Health-Care-Brief-2020.pdf accessed online [10th August 2022]

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