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Strategic Action Plan for suicide Prevention, Intervention and Postvention

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Summary

Suicide is a major public-health issue, with wide-ranging consequences for society as a whole. In Iceland an average of 41 suicides have occurred annually for the past five years (2019-23). Research has demonstrated that every suicide is at great cost to society, and in addition every suicide has an impact on the health and wellbeing of many individuals with a connection to the deceased. Effective suicide prevention measures are conducive to those who need help receiving appropriate support at all stages; in that way further problems may be prevented, so that more costly measures are not required in response to declining ability to deal with the activities of daily life and pursue education or employment. Funding devoted to suicide prevention will repay itself many times over to society. An effective strategy is thus a valuable addition to the tools available for promoting improved health among the people of Iceland.

The strategy will be a supportive addition to existing policies and plans in the field of mental health and public health. The plan has been drawn up with reference to evidence-based knowledge of suicide and suicide prevention, from both Iceland and abroad. Account has been taken of guidance from the World Health Organisation, clinical guidance, and focusses in suicide prevention which have proved effective internationally.

The strategy, which covers a period of five years, 2025 to 2030, comprises 26 measures. These include targeted and evidence-based suicide prevention measures at all stages – both general and specialised. These call for extensive, coordinated collaboration and co-creation between government ministries and service systems. The measures entail inter alia education and consistent working methods in the media, as well as in the services provided by gatekeepers and healthcare personnel. The objective is to enhance knowledge and skills in order to respond supportively and appropriately at all levels of service. The strategy also includes measures regarding the analysis of statistics on suicide in Iceland. It entails provisions for limiting access to hazardous objects and circumstances, and measures regarding work on the selection and creation of educational material for children and young people. By the same token, there are measures relating to raising awareness regarding mental health and suicide prevention.

Each of the measures provided in the plan is defined by its objective, the responsible bodies, stakeholders, yardsticks of success, and cost analysis. This provides support in prioritisation and focussed delivery and will ensure positive results. The measures have been prepared in collaboration with the Ministry of Health, other ministries of the government and institutions, and other stakeholders. Project management is handled by Lífsbrú – the centre for suicide prevention at the Directorate of Health. The progress of the measures will be monitored, and a status report on the strategy will be issued annually. In addition, the measures will be reviewed and updated based on the latest research and knowledge of suicide prevention.

The seven categories on which the action plan is based are:

1. Coordination and organisation
2. Support and treatment
3. Limit access to hazardous substances, objects and circumstances
4. Awareness and education
5. Prevention and health promotion
6. Quality control and expertise
7. Support for those bereaved by suicide

Abbreviations and vocabulary

SUPRA (SUICIDE PREVENTION AUSTRIA)	Suicide prevention strategy for Austria
Papageno effect	Responsible media coverage of suicide, which has a preventive impact upon suicide rates. This effect is named after the character Papageno in Mozart's *Magic Flute*, who considers suicide, but changes his mind, having realised that there are better options.
Werther effect	Media coverage which may give rise to higher risk of suicide. When media reporting has an impact leading to higher suicide rates, this has been named after Werther, a character who dies by suicide in Goethe's novel *The Sorrows of the Young Werther.*
Prevention	All measures, general and specialised, which are intended to prevent suicide.
Intervention	All measures applied with the objective of preventing a person with suicidal ideation or behaviour from attempting suicide. Intervention also includes specialised support for those who have attempted suicide.
Postvention	Postvention comprises support of two kinds for those bereaved by suicide. On the one hand, support to enable the bereaved to manage their daily lives and attain a certain stability. On the other, to prevent possible health problems – physical, mental or social.

Gatekeepers	Those who, through their work, are involved with those who may be at risk of suicide. Gatekeepers must be aware of the risk factors for suicide and be able to recognise signs of risk. Gatekeepers include e.g. emergency response personnel, providers of pastoral care, teachers, and social and health service personnel.
Hot spots	Locations or structures where suicides have taken place repeatedly or could take place.
Exposure	After any suicide, there is an impact upon many people in the immediate environment of the deceased, due to the suicide. The impact varies according to the relationship with the deceased close relatives, close friends and mental health professionals are more likely to experience long - term impact.
Suicidal behaviour	Entails thoughts of suicide, making concrete plans for suicide, and attempting suicide with a firm intention of dying.
Suicide contagion	Rise in suicide rate and suicidal behaviour due to the impact of suicide or suicidal behaviour within a family or peer group or following media coverage of suicide.
Co-creation	Collaboration among diverse parties in the design or making of a product, procedure or service. This methodology guarantees the involvement of all stakeholders and maximises the quality of the product.
Pastoral care	Concept applied to professionals who provide pastoral care, such as priests and other spiritual advisers, deacons, and others who

	provide pastoral care after a suicide.
Peer support	Support from an individual who has comparable life experience to the individual in receipt of support. This may consist of experience of mental challenges, personal experience of suicidal ideation, having attempted suicide, or having a loved one who faces mental challenges. Peer support is also applied following a suicide: the bereaved has the opportunity to express their feelings and malaise to someone who has also been bereaved but has progressed further in the grieving process.
Peer	A person who provides peer support – by listening, being present, and sharing experience if requested.

Introduction

Suicide is a public-health issue which has wide-ranging health, societal and economic consequences. In Iceland an average of about 41 people have died by suicide in each of the last five years (2019 - 2023).[1] Because of the small population (under 400,000), small differences in absolute numbers of suicides may give rise to considerable fluctuations in the suicide rate from year to year. Hence it is appropriate to use five- to ten-year averages in addressing suicide rates in Iceland. The suicide rate averaged 11.8 per 100,000 population for the years 2013 – 2023: 17.8 for men and 5.7 for women. For comparison: among the five Nordic countries, Iceland's suicide rate is the next-lowest. Rates in Finland, Norway and Sweden are higher, while Denmark has a lower rate. The Åland islands, the Faroes and Greenland are not included in these Nordic statistics.[2]

International research demonstrates that every death by suicide is at great cost to societies – both in terms of direct and indirect costs.[3,4] Each suicide is believed to have an impact on up to 135 individuals in the immediate environment of the deceased.[5] Research findings indicate that every ISK (Icelandic currency) spent on suicide prevention measures will be recouped twice to four times over.[6] It is probable that this conclusion may also be applied to Iceland.[7]

An important step in suicide prevention was achieved in 2023, when the decision was made to allocate permanent funding for suicide prevention measures, and the *Lífsbrú* suicide prevention centre was founded under the aegis of the Directorate of Health.[8] *Lífsbrú* will provide an overview of the status and progress of work on the measures under the *strategy*. *Lífsbrú* will promulgate information on new knowledge in this field and will support the updating of educational material etc. as required.

A *Suicide Prevention strategy for Iceland* (2018)[9] was constructed on the basis of the Mental Health Policy for 2016 - 2020. It is vital to update measures for suicide prevention, adapt them to the latest scientific advances, and connect the measures with existing mental-health policy[10] and strategy,[11] as well as public-health policy,[12] alcohol- and substance-abuse prevention policy[13] and health policy.[14] Therefore the Minister of Health appointed a working group to prepare a new *strategy* for suicide prevention. The working group was assigned to examine the previous strategy, and on that basis to create a cost-assessed strategy based on the best data on suicide prevention, adapted to present-day conditions, and in keeping with existing health-related policies. The measures were to be defined by objective, responsibility, collaborating parties and societal impact.

The working group began work in February 2024.

Its members were:

Guðrún Jóna Guðlaugsdóttir, project manager at the Directorate of Health (chair).

Ásta Ingibjörg Pétursdóttir, pastor at Langholtskirkja church.

Guðríður Haraldsdóttir, psychologist at Geðheilsumiðstöð barna (Children's Mental Health Centre)

Grétar Björnsson, sociologist, on behalf of Hugarafl (Mindpower) and Geðráð (Mental Health Commission).

Ingibjörg Sveinsdóttir, psychologist, senior advisor at the Ministry of Health.

Jóhanna María Eyjólfsdóttir, deacon and programme director at Sorgarmiðstöð (Grief Centre).

Liv Anna Gunnell, programme director of psychological services at Þróunarmiðstöð íslenskrar heilsugæslu (Development Centre for Primary Healthcare in Iceland).

Sigrún Sigurðardóttir, professor at the University of Akureyri, on behalf of the Geðhjálp mental health federation.

Sigurður Páll Pálsson, physician at Landspítali University Hospital department of psychiatry.

Tómas Kristjánsson, psychologist, on behalf of Pieta suicide support charity.

Vision

The vision for the future is that the number of suicides in Iceland should be greatly reduced from the present rate. The objective of the *strategy* is to introduce effective measures which are grounded in the best evidence-based knowledge, and thus in a focussed manner to reduce the suicide rate in Iceland. Attention is paid to the entire life experience, with emphasis on preventive measures, intervention and support for family and friends, through both general and specialised measures. The principle is that together all the different levels shall constitute an integrated safety-net of suicide prevention measures.[15]

- **Prevention:** To reduce the number of suicides by aiming to guide the individual from reaching a point where they see no other way out than suicide. This refers to general measures, with the aim e.g. of promoting the social and emotional skills of children and young people, and also special measures aimed for specific risk groups, e.g. those who experience trauma or breakdown of health.
- **Intervention:** To reach out to those who experience suicidal ideation or suicidal behaviour, to provide them with assistance and thus potentially to prevent suicide.
- **Postvention after a suicide:** Provide support for family and friends, and professionals in the field, in working through trauma following a suicide, and mitigate the potentially grave impact on health and wellbeing.

Picture 1: *All the levels of suicide prevention*

Methodology

The revision of the *Suicide Prevention strategy* was based upon the Health Policy until 2030, approved by parliament in 2019; the public health policy until 2030 approved by parliament in 2021; the alcohol- and substance-abuse prevention policy until 2020; and the mental-health policy until 2030 and the accompanying strategy 2023 – 2027, which were approved by parliament in 2022 and 2023. Together these policies and strategies constitute an integrated framework for promotion of public health and effective health services. The *Suicide Prevention strategy* is one more tool to work towards improved health and wellbeing among the people of Iceland.

The working group reviewed the prior *strategy* from 2018, and the experience of its implementation. That plan put forward 54 extensive measures which were the responsibility of many different ministries, institutions and NGOs. The plan itself lacked dedicated funding, and for that reason it has proved difficult to complete the measures. Overall, 15 of the 54 measures may be said to have been achieved. An example of a measure that has been successfully completed is *preparation of safety checklists with respect to suicide prevention at medical and addiction treatment facilities, group homes and nursing homes.*[16] Other measures are of such a nature that they must be revisited, e.g. if new knowledge emerges. An example of such a measure is *guidelines for media for responsible reporting of suicide*, which was completed in 2019.[17] As knowledge in this field has been progressing rapidly, these guidelines must be revised, and hence this measure features again in the new *strategy*. Thus, it is important to bear in mind that, even though certain measures may have been completed, they must remain under constant review at the *Lífsbrú* suicide prevention centre.

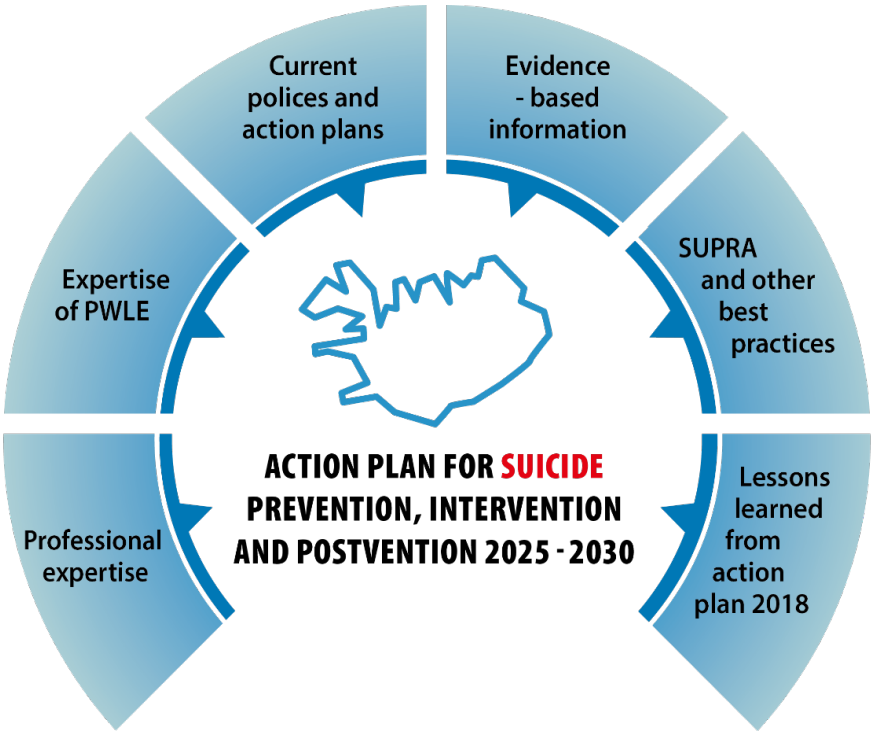
In drawing up the original *strategy*, account was also taken of the latest international developments in suicide prevention, with emphasis upon measures which have been proven to be effective. An examination was made of what measures were common to all the strategies, and the underlying research was reviewed. It is clear that, both in Iceland and elsewhere, there is growing emphasis on public health, preventive measures and mental health care. Emphasis is also placed upon the response following a suicide and providing greater care for the family and friends of those who have died by suicide.

The working group applied specialist knowledge in this field from both Iceland and abroad, and the experience of professionals and service-users, in addition to examining prevention programmes from around the world.

Use was made of evidence-based guidelines from the World Health Organisation regarding the preparation of a holistic national prevention plan.[18] Those guidelines propose that all plans should include the following measures:

1. Limit access to the means of suicide
2. Interact with the media for responsible reporting of suicide
3. Foster socioemotional skills in adolescents
4. Early intervention for identification, assessment, management and follow-up of those displaying suicidal behaviour

Iceland had two representatives in the EU project *Joint Action (JA) ImpleMENTAL*[19] 2021-2024, one from the Directorate of Health and the other from the Ministry of Health. The objective of this project is to strengthen mental health services in European countries by implementing evidence-based suicide prevention measures, following the Austrian example *SUPRA*[20] (Suicide Prevention Austria), and promoting evidence-based measures in mental health services following the Belgian example.



Picture 2: *Factors upon which the strategy is based*

In its work the working group took account of the above-mentioned *SUPRA* suicide prevention project, which is regarded as outstanding in suicide prevention. *SUPRA* places emphasis on clear policy, and measures based on that policy. Emphasis is placed upon measures which are easily implemented, well defined, financially viable, and yield a rapid and measurable outcome. In *SUPRA* this principle is called "quick win." *SUPRA* is based upon six factors, and the working group decided to follow the Austrian example, while adding a seventh factor: support for those bereaved by suicide. That factor was also included in the prior *strategy* in 2018.

In drawing up this new *strategy*, account was taken of all the above-mentioned factors, and emphasis was placed upon selecting effective, well-defined and practicable measures. It was also decided that a cost analysis was a necessary premise for prioritisation of measures and funding them.

1. Coordination and organisation
2. Support and treatment
3. Limitation of access to hazardous substances, objects and circumstances
4. Raise awareness, education
5. Preventive measures, health promotion
6. Quality control, expertise
7. Support for those who bereaved by suicide

Proposal of measures and consultation

The report has been prepared in extensive consultation with stakeholders' representatives.

The working group called in specialists as required, e.g. representatives of the relevant ministries, interest groups and institutions. The measures in the *strategy* number 26 in total. These are represented in the tables, and below each table the arguments for the measures are put forward, in a statement of the objective of each measure, societal impact, and the bodies which are to implement the measure and bear responsibility for it. The enumeration of stakeholders in the tables is not exhaustive; the intention is that in the development of each measure an analysis of stakeholders will be carried out. A yardstick of success is established for each measure.

The working group submitted its vision and *strategy* to the Minister of Health in December 2024, together with a memorandum proposing prioritisation of measures. The *strategy* was then opened up for public consultation via the digital consultation gateway *Samráðsgátt*. The deadline for submissions was 4 March 2025. Comments were received from four NGOs. The tone of the comments was generally favourable; constructive suggestions were made, and organisations also offered to contribute to further work in this field. Some of the suggestions were more relevant to the Mental Health Strategy, rather than the Suicide Prevention Strategy, and these were passed on to the relevant parties at the Ministry of Health. Following the comments received, no material alterations were deemed necessary in the *strategy*, but certain items were reworded in accord with suggestions. Following consultation, a time and cost estimate will be made for each measure in the *strategy*.

In follow-up on the *strategy*, the Ministry of Health will receive regular updates on the status of individual measures from the project manager at *Lífsbrú* suicide prevention centre. These updates will state what factors have been conducive to success, and what hinders progress, with the objective of ensuring their progress. Measures must be reviewed, so that they are always based on the latest knowledge, and in order to maximise results. An evaluation of overall success will be carried out regularly – next in 2027. The objective is that the public should be able to monitor progress on this matter via an interactive dashboard on the government website and at *Lífsbrú* suicide prevention centre.

The working group expresses the hope that this plan will serve the people of Iceland well.

1. Coordination and organisation

The objective of the measures is to conduce to coordinated suicide-prevention measures in Iceland.

Table 1: *Coordination and organisation*

Action	Purpose	Responsibility	Stakeholders	Community	Measure
1.1 Research - That an analysis of suicides be conducted going back to the year 2000.	Examine demographic variables and other risk factors to improve suicide prevention in Iceland.	Directorate of Health	Ministry of Health, Lífsbrú center of suicide prevention, University of Iceland, University of Akureyri, Healthcare services	Increased ability to work on improved wellbeing and suicide prevention.	Publication of a report and peer-reviewed articles.
1.2 Risk factors - That, alongside the analysis of suicides (1.1), a process be developed to allow for annual monitoring of the same risk factors.	To monitor the development of risk factors in Iceland to improve suicide prevention and reduce the number of suicides.	Directorate of Health	Ministry of Health, Lífsbrú center of suicide prevention, University of Iceland, University of Akureyri, Healthcare services	With increased knowledge, suicide prevention in Iceland becomes more targeted.	That results on risk factors are available at the Directorate of Health.

Lífsbrú suicide prevention centre functions under the aegis of the Directorate of Health. Under the Director of Health and Public Health Act no. 41/2007, article 3, the Directorate of Health has the mandated role of working on prevention.[21] *Lífsbrú* is a forum for the gathering of knowledge, development and measures in the field of suicide prevention. *Lífsbrú* undertakes coordination and organisation and monitors the measures put forward in the *strategy*; in due course information will become available there as the work progresses, e.g. guidelines, checklists and educational materials. *Lífsbrú* is a forum for collaboration and co-creation in suicide prevention, and it carries out research in the field.

Hitherto, little research has been carried out on suicide prevention in Iceland. In addressing the subject of suicide in Iceland, reference has been made to research in other countries on risk factors for suicide. In order to achieve results in suicide prevention, it is important to be aware of the risk factors that exist in Iceland, in order to apply focussed suicide prevention measures. In 2024 the Data Protection Authority and the National Bioethics Committee granted permission for a study of risk factors for suicide. The study is carried out under the aegis of *Lífsbrú* in collaboration with the University of Iceland, the Centre of Public Health Sciences, the University of Akureyri, Landspítali University Hospital and the Directorate of Health.

This study is the beginning of a detailed root-cause analysis of every suicide, connections with databases, institutions, medications, etc. A draft resolution proposing comparable root-cause analysis was submitted to parliament in the spring of 2024.[22] Alongside the present study, it is proposed that a procedure be created to enable regular examination of risk factors, and interaction of risk factors, that may be revealed by the study.

2. Support and treatment

The objective of the measures is that people at risk of suicide receive the appropriate support.

Table 2: *Support and treatment*

Action	Purpose	Responsibility	Stakeholders	Community	Measure
2.1 Adults have access to low-threshold resources - Ensure access to appropriate, evidence-based, low-threshold interventions without waiting periods for adults experiencing suicidal thoughts.	People in serious distress or experiencing suicidal thoughts have facilitated access to specialised services without waiting periods, regardless of where they live, their abilities or social circumstances.	Ministry of Health	Directorate of Health, Healthcare services, Specialised NGOs	Easier access for users to appropriate support in times of severe distress, fewer suicide attempts, improved wellbeing	The number of adults who seek low-threshold resources due to the risk of suicide.
2.2 Children have access to low-threshold resources - Ensure access to appropriate, evidence-based, low-threshold interventions without waiting periods for young people experiencing suicidal thoughts.	Children and young people in serious distress or experiencing suicidal thoughts have easy access to specialised services without waiting periods, regardless of where they live, their abilities or social circumstances.	Ministry of Health	Directorate of Health, Healthcare Services, Specialised NGOs	Easier access for children and young people to appropriate support in times of sever distress, fewer suicide attempts, improved wellbeing.	The number of young people who seek low-threshold resources due to the risk of suicide.
2.3 Ensured electronic access to evidence-based information – Ensured electronic access to information on appropriate responses to suicidal thoughts, self-harming behaviour and support after a suicide attempt, including an overview of resources, for users of all ages.	Users with thoughts of self-harm or self-harming behaviour and their support persons have easy access to information on appropriate responses and resources.	Ministry of Health	Ministry of Health, The Development Centre for primary healthcare in Iceland, Landspitali University Hospital, Healthcare Services	Users have easy access to information and therefore better access to appropriate resources. Improved wellbeing. Less self-harm.	That material is available, open and accessible on the webpage Heilsuvera.

2.4 Clearly coordinated procedures after a suicide attempt - That healthcare centres, healthcare institutions and hospitals where applicable, have clear procedures for assessment, treatment and follow-up after a suicide attempt.	2.4 Users receive appropriate support after a suicide attempt.	Directorate of Health	Ministry of Health, The Development Centre for primary healthcare in Iceland, Landspítali University Hospital, Healthcare Services	Users receive appropriate support after a suicide attempt.	The proportion of healthcare centres, healthcare institutions and hospitals that have implemented procedures after a suicide attempt is 100%.

The World Health Organisation emphasises that certain measures should be included in all suicide prevention strategies. These include measures that are conducive to ensuring early intervention for those who are experiencing suicidal ideation, or have made previous suicide attempts, through appropriate assessment, support and follow-up. Ready access must be ensured to timely, simple and accessible low-threshold provisions for people with suicidal ideation and their family and friends, regardless of age, place of residence, social circumstances or underlying problems. Ideally, service-users should have the option to telephone, send a message, or have a face-to-face conversation. An example of a low-threshold provision is an emergency number which can be called 24 hours a day, where specialised evidence-based service is provided. Individual support must be ensured, based upon evidence-based methods and taking account of the physical and mental health and social circumstances of the individual, and providing appropriate follow-up for those who are dealing with suicidal ideation. Two measures are concerned with ensuring access to low-threshold provisions: one for adults, another for children and young people.

It must be ensured that provisions meet the diverse needs of all service-users.

Peer support can give service-users hope, enhance their wellbeing, and thus reduce their malaise. Peer support can also be a good form of support for family and friends, both personally, and in helping them be supportive of the family member/friend with suicidal ideation. It is being used increasingly in health service and within NGOs both in Iceland and elsewhere.23

Today provisions are offered by NGOs in accord with the first two measures (2.1 and 2.2), operating low-threshold provisions at no cost to the individual. Such NGOs are largely funded by voluntary contributions from individuals, as well as grants, so their future is insecure. These measures are important in order to ensure ongoing service. It is also essential to monitor the development of the service, and waiting-times; and it is clear that the government must take decisive action in order to ensure low-threshold support and service, regardless of where the person lives.

It is important that staff providing low-threshold services, and the general public, should have good knowledge of the provisions accessible to service-users in their immediate environment, so that the individual receives appropriate service without delay. One means of promoting such awareness is to ensure the availability of online educational/information materials about response and

provisions regarding suicidal ideation or behaviour, and support following a suicide attempt or a suicide. Measure 2.3. aims to ensure the availability of such materials.

A major predictive factor for suicide is a prior suicide attempt.24,25 Hence it is a priority that there should be clear coordinated procedures within public institutions, where applicable, for assessment, treatment and follow-up following a suicide attempt. The Directorate of Health has been granted funding by the Ministry of Health via the Mental Health Strategy until 2027, to commence work on this matter within the *Lífsbrú* suicide prevention centre. That work is at the preparatory stage.

3. Limit access to hazardous substances, objects and circumstances

The objective of the measures is to reduce as far as possible means that may lead to suicide.

Table 3: *Limit access to means of suicide*

Action	Purpose	Responsibility	Stakeholders	Community	Measure
3.1. A root cause analysis of medicinal products - That a root cause analysis be conducted on drugs that have been used in suicide attempts.	Gather information on whether there is a need to revise regulations on the packaging sizes of medicinal products and/or ensure appropriate unit pricing of medicines.	Directorate of Health	Ministry of Health, Healthcare Services	Limit access to drugs that have been used in suicide attempts in Iceland in quantities capable of causing death.	An overview of what drugs are used for suicide attempts.
3.2 Preparation of guidelines for prescribing medicines - That guidelines are developed on best practices for doctors when prescribing medicines with side effects that may promote or increase risk of suicidal thoughts.	Develop guidelines on best practices for physicians that ensure individuals are informed about potential side effects of medications that may promote or increase risk of suicidal thoughts.	Directorate of Health	The Development Centre for primary healthcare in Iceland, Healthcare Services, Medical association, Icelandic Pharmaceutical association.	Ensure that users are informed of serious side effects of medicines when prescribed.	On EL's website, guidelines are available on good practices for doctors when prescribing drugs that can promote suicidal thoughts in accordance with clinical guidelines.
3.3 Safety checklist should be considered when setting construction requirements for institutions - That a safety checklist is taken into account when setting construction requirements for hospital, treatment institutions, residential centres and nursing homes.	Restrict access to locations and situations where suicide may occur.	Directorate of Health	The Ministry of Finance, The Government Property Agency.	Reduced access to areas and situations where suicide can occur.	Introduction of the checklist to relevant partners.

An effective means of reducing the number of suicides is to limit access to potentially lethal elements. Emphasis is placed upon limiting access firstly to

the most hazardous elements, which cause the greatest number of deaths. Thus attention has to be paid to circumstances in each country individually. Success has been achieved by such methods in neighbouring countries, e.g. by measures that aim to limit access to bridges and tall buildings, and via special measures at train stations.

The 2018 *strategy* included seven measures which aimed to limit access, and positive results have been achieved in Iceland: see below.

- An important step has been taken with the establishment of a centralised Prescription Medicines Database and enhanced monitoring of dispensing of medications, e.g. with the requirement to show ID when receiving prescription medications. This measure has thus been completed.
- A revision of regulations on ownership and custody of firearms and ammunition was proposed in the context of suicide prevention. This may be said to have been achieved via a resolution to amend the provision on secure storage of firearms which took effect in June 2014.26 The amended provision states the requirement that owners of firearms must have secure storage lockers for all firearms, while before the requirement applied only to those who owned three or more firearms.
- Lífsbrú explored whether it was necessary to direct attention to specific locations (hotspots) in the context of suicide prevention, i.e. whether more suicides occur in certain areas than others. The findings did not indicate the existence of any hotspots in Iceland. This measure has thus been completed; but in order to ensure monitoring of possible development of hotspots, a procedure has been introduced at Lífsbrú in collaboration with specialists at the Directorate of Health, based on autopsy reports and death certificates.
- A patient safety checklist with respect to suicide prevention was introduced in medical and addiction treatment facilities, group homes and nursing homes.27 The checklist was produced by an interdisciplinary group and published in 2022.
- A procedure was introduced regarding access to and use of opioid antagonists; and naloxone is now accessible in spray form in all police vehicles and ambulances in Iceland, as well as at dedicated consumption sites for opioid users.

In Iceland the most common means of suicide are hanging, drug overdose and use of firearms, and so it is essential to place emphasis on those factors. Two measures focus on drugs.

The former, 3.1, entails a root-cause analysis of pharmaceuticals which have been used in suicides or suicide attempts. It is proposed that the first step should be to analyse which drugs are being used, followed by encouragement to use drug cabinets in the home. In addition, such cabinets should be visible and accessible where drugs are dispensed – as it may be a preventive element against self-harming behaviour for drugs to be stored in a locked cabinet. Raising of awareness on this matter could follow in due course, as well as

revisions of regulations on sizes of packages of pharmaceuticals, and ensuring a standard unit price for pharmaceuticals.

The second preventive measure, 3.2, relates to pharmaceuticals, with the objective of producing guidelines for best practice for physicians in prescribing drugs with increased risk of suicidal behaviour as a possible side-effect. This is done in order to underline the importance of awareness of such side-effects. In preparation of such guidelines, account may be taken of guidelines from both Iceland[28] and elsewhere.[29] That could be followed by an awakening of awareness of the importance of reading the information leaflet accompanying medications, being aware of side-effects, and asking questions as appropriate.

The third measure in this section, 3.3, serves to ensure that account should be taken of the above-mentioned safety checklist in construction and/or refurbishment of medical and addiction treatment facilities, group homes and nursing homes. The safety checklist covers many factors, but it serves not least to prevent possible means of hanging. The measure entails extensive promotion of the safety checklist to stakeholders.

The link between use of alcohol and drugs and suicide is well known. According to the World Health Organisation the most effective way to reduce harmful problems relating to alcohol and drug use is to limit access to them.[30] Work is in progress in Iceland on this objective with the current alcohol- and substance-abuse prevention policy. Hence no specific measure on this matter is included in this *strategy.* A new policy on alcohol- and substance-abuse prevention is in preparation.

4. Awareness and education

The objective of the measures is that awareness and knowledge of mental challenges, and means of coping with psychosocial challenges and traumas, should be widespread among the general public.

Table 4: *Awareness and education*

Action	Purpose	Responsibility	Stakeholders	Community	Measure
4.1 Guidelines for the media - To ensure that the media are provided with guidelines on responsible coverage of suicide.	That the media's coverage of suicide is based on evidence-based methods.	Directorate of Health	Ministry of Health, BÍ, the media.	Suicide will be discussed with respect, in a responsible and constructive manner.	Guidelines on responsible discussion of suicide are available on the website of Lífsbrú and on ASI's website.
4.2 Education in basic and/or continuing education of media workers - Bringing education on suicide prevention into basic and/or continuing education for individuals that work in the media.	Members of the media should have knowledge of all stages of suicide prevention.	Directorate of Health	Ministry of Health, Lífsbrú, Ministry of Culture, Innovation and Higher Education	Suicide will be discussed with respect, in a responsible and constructive manner.	Material is included in the curriculum of media studies at the University of Iceland.
4.3 Preparation of educational material and teaching for gatekeepers - Selection and preparation of educational material on suicide prevention that includes: prevention, intervention and support following suicide. Gatekeepers include, for example, pastoral care providers, emergency responders, prison staff, school and social service staff, helpline staff and healthcare workers.	Gatekeepers have knowledge of all stages of suicide prevention so that they can respond to users appropriately and refer to appropriate services.	Directorate of Health	Ministry of Health, Ministry of Children and Education, Ministry of Justice, Ministry of Social Affairs and Labour, The Development Centre for primary healthcare in Iceland, specialised NGOs, institutions and experts in suicide prevention	Early and appropriate support for users, improved wellbeing of users and fewer suicide attempts.	Educational material available on the website of Lífsbrú.

4.4 Education in basic education for all gatekeepers - Introduction of education on suicide prevention in the basic education of all gatekeepers.	Gatekeepers have knowledge of all stages of suicide prevention.	Ministry of Health	Ministry of Culture, Innovation and Higher Education, Ministry of Health, Directorate of Health, The Development Centre for primary healthcare in Iceland, FVR, health institutions	Users receive appropriate support, improved wellbeing for users, fewer suicide attempts.	Number of groups of gatekeepers where suicide prevention is part of the curriculum.
4.5 Professionals attend regular training - That professionals in health and social services attend regular training on suicide risk assessment.	Professionals know how to assess the risk of suicide and respond appropriately.	Managers in social and health services	Directorate of Health - Lífsrú center of suicide prevention	Users receive early, appropriate support, improved wellbeing of users, fewer suicide attempts and suicides.	80% of working professionals in health and social services go through the training every other year.
4.6 Awareness for the public - Raise awareness about mental health and suicide prevention.	The public has knowledge of mental health and suicide prevention and can seek appropriate help in distress.	Directorate of Health	Institutions and NGOs that work on suicide prevention.	The public will gain better knowledge about mental health, coping strategies and resources.	Annual awareness campaign on suicide prevention.
4.7 Raising awareness for at-risk groups - Raise awareness about mental health and suicide prevention for at-risk groups, e.g. men, young people, prisoners, police officers, and people with alcohol and drug problems.	To increase awareness among at-risk groups about mental health and suicide prevention, allowing them to seek appropriate support in times of distress.	Directorate of Health	Institutions and NGOs that work on suicide prevention.	To ensure that at-risk groups receive education about mental health, coping strategies and resources.	Increased awareness within at-risk groups.

Despite increased and more open discussion of mental-health issues, prejudices still exist regarding suicide and suicidal ideation. It is essential that people with thoughts of self-harm or suicide should be able to speak about their malaise or thoughts of self-harm and/or suicide, and to seek assistance. Hence it must be ensured that everyone has access to information on means to maintain good mental health, and to relevant advice and provisions regarding malaise, whether by searching online, or seeking advice from friends or

relatives, or gatekeepers in their immediate environment, or by consulting professionals. That entails that the *strategy* includes many measures which are intended to promote enhanced knowledge of suicide prevention, both in general and for at-risk groups.

Research demonstrates that, by responsible press coverage of suicide, it is possible to prevent such coverage conducing to further suicides (the Werther effect); and it has been shown that such coverage may also prevent suicide (the Papageno effect). Thus measure 4.1 of the *strategy* is to ensure good access for the media to guidance on responsible coverage of suicide, and to ensure that such coverage should be part of the basic training of media personnel. There is a strong evidence base that responsible media coverage of suicide is of importance.[31] Guidelines for the media on responsible coverage of suicide were published in 2019, and a project group has been established at *Lífsbrú* to update the guidelines in accord with the latest knowledge. The work is progressing well.

Raising awareness as proposed in measures 4.6 and 4.7 aims to promote greater knowledge of suicide prevention among the public and risk-groups. The objective is that discourse on suicide should take place with respect and free of prejudice; that people should be aware of useful advice and provisions, and that encouragement to seek assistance when needed should be included. It is important to ensure easy access to the appropriate support. The general public need to be informed about how best to have conversations regarding malaise and suicidal ideation.

The awareness-raising programme *Yellow September* has been launched. This vigilance campaign is a collaborative venture of various public bodies and NGOs in the field of mental health and suicide prevention, while project management is handled by *Lífsbrú*. A new feature of the *Yellow September* programme was introduced in 2024, when the first *Lífsbrú* awards were made to an individual and to a group for their contributions to suicide prevention. Precedents for such awards include e.g. the Papageno Prize in Austria and Estonia, and *Olafprisen* in Norway.

It is necessary to discuss subjects such as death, suicide, mental health care, a common health problem, and how one can respond to difficult circumstances. Gatekeepers must be aware of where people can seek help with their malaise, and how it is good to deal with, and help others deal with, problems. Measures 4.2, 4.3, 4.4 and 4.5 provide for special education on suicide prevention to be added to joint training and basic education for gatekeepers in the immediate environment, such as emergency response personnel, providers of pastoral care, prison staff, school staff, helpline staff and healthcare personnel. Increased knowledge of suicide prevention among support personnel in the immediate environment will enhance the likelihood of early intervention, leading to appropriate support and preventing worsening of the problem.

It is especially important that people in front-line service such as teachers, police officers, healthcare personnel and emergency/helpline staff should receive specialised training in evidence-based response to suicide risk, in order

to be able to support service-users, and to direct them onward to appropriate service as required. The intention is that coordinated evidence-based procedures should be used in public institutions, where appropriate, in treatment and follow-up following a suicide attempt, see measure 2.4.

Research in other countries indicates that many people have sought professional help before resorting to suicide. It is necessary to ensure that professionals in health and social care maintain their knowledge of how to assess suicide risk.[32 33 34 35 36] There is considerable development of knowledge in this field and, in order to conduce to ongoing education based upon the latest knowledge, measure 4.5 has been added.

At *Lífsbrú* work is under way on measure 4.3: production of educational materials for providers of pastoral care. The members of the working group have been appointed: they possess extensive professional knowledge of the matter, and the material they produce will be reviewed and tested by a cross-disciplinary group of specialists. The educational material is grounded in evidence-based sources and adapted to Icelandic culture and circumstances. In the educational material, the importance is pointed out of providers of pastoral care practising self-care and receiving guidance in their work. When the material is ready for use by working providers of pastoral care, it will go on to be available as part of the educational materials for basic training in the same professions, see measure 4.4.

It is important to ensure that suicide prevention is added to the joint training and basic education for gatekeepers in the environment of children and young people on mental health, violence prevention and prevention of substance abuse.

5. Prevention and health promotion

The objective of the measures is that suicide prevention be integrated with other measures conducive to health promotion and prevention on a broad basis.

Table 5: *Prevention and health promotion*

Action	Purpose	Responsibility	Stakeholders	Community	Measure
5.1. Collaboration on selecting, processing and publishing evidence-based learning materials - To establish collaboration between the Centre for Education and School Services and the Directorate of Health in selecting, developing, processing and publishing evidence-based learning materials that enhance the social and emotional skills of children and young people at all school levels.	Ensure that schools always have access to high-quality curriculum in the field of mental health for children and young people at all school levels.	Directorate of Health	Ministry of Health, Ministry of Children and Education, Centre for Education and School Services	Students receive high-quality study material on mental health that leads to improved wellbeing of students.	That there is active collaboration between the project manager of mental health at EL and the coordinators of educational material publishing at MMS regarding the publication of study material in the field of mental health and life skills.
5.2 Suicide prevention is part of mental health education - Suicide prevention is a part of mental health education for school children in 10th grade.	Students receive fundamental education on suicide prevention and resources.	Ministry of Health	The Development Centre for primary healthcare in Iceland, Lífsbrú, Healthcare Institutions	That all children at the top level of primary school receive education on suicide prevention, how to respond and where to turn if they or individuals around them experience distress.	The proportion of children in 10th grade who have received education on suicide prevention is 90%.
5.3 Educational material is available online - That digital learning materials be prepared for the oldest grades of primary school based on evidence-based educational material on suicide prevention and support. The education will be a part of mental health education for school children.	That there is educational material on suicide prevention and support for adolescents.	Directorate of Health	Ministry of Health, Ministry of Children and Education, Icelandic Health Care Development Centre, health institutions	Digital material available for use in the health protection of school children.	That digital educational material on suicide prevention is available and accessible on the internal web of ÞÍH for the health protection of schoolchildren

Childhood is an important time for development in mental health and lays the foundation for mental health lifelong. Opportunities for promoting good mental health are greatest in the early years: half of mental problems have already manifested by the age of 14,[37] and around 75% by the age of 25.[38]

With respect to mental health care and suicide prevention, the World Health Organisation emphasises *inter alia* the need to promote resilience, and to seek to improve young people's social and emotional skills. As most children and young people are in school, this is deemed an appropriate setting for teaching and practising social and emotional skills in a focussed manner. Through focussed tuition in social and emotional skills, children and young people gain understanding and knowledge of their own wellbeing, and learn to make use of effective methods of dealing with emotions, stress and social issues, and where to go for help if needed.[39] They receive regular training in social skills, learning to understand others' viewpoints, to compromise, and to settle disputes successfully.

The first measure, 5.1, entails consultation between *Miðstöð menntunar og skólaþróunar* (Centre of Education and School Service) and the Directorate of Health regarding the selection, preparation and publication of evidence-based study materials to promote resilience and social and emotional skills among children and young people in Iceland's primary and secondary schools. In this work it is desirable to make use of a report based upon a national survey of mental-health work,[40] and also a report on study materials and the overall school approach to promoting social and emotional skills in schools.[41] The study material must take account of age and available provisions, depending upon the nature of the problem.[42]

In order to ensure the effectiveness of prevention measures and health promotion, a positive and supportive study and social environment must be introduced, along with a holistic system of procedures, working methods and supportive provisions. An environment and forum must be created where children and young people can bond with teachers and other staff, build up trust, and be able to tell them about malaise due e.g. to trauma arising from bullying or violence; and where procedures are in place for appropriate responses.

At present students in year 10 (aged 15-16) receive education on mental health within the framework of Schoolchildren's Healthcare, which is a legally-mandated service in primary/lower secondary schools (years 1 to 10, ages 6 to 16). The second measure, 5.2, entails the addition of basic education on suicide prevention and provisions. The objective is that all young people should know how to respond to mental challenges, and where to go for help. It is desirable that parents/guardians should receive information at the same time from the school nurse about the education, provisions and appropriate response to malaise. Education and discussion of mental health and mental problems has proved to reduce prejudices, and to be helpful for young people; it is essential to ensure high quality of education, working with evidence-based methods. Interdisciplinary collaboration between school nurses, school staff and other professionals on such education is important. The annual report of

Schoolchildren's Healthcare provides information on the number of pupils receiving this education, and where in the country they live.

The third measure, 5.3, entails production of educational material in digital form for young people about appropriate responses to, and provisions for, their own suicidal ideation or self-harming behaviour, or that of friends or other individuals around them. Research shows that courses on prevention may serve to enhance the participants' skills in recognising suicide risk, and responding in a safe manner.[43,44] It is proposed that the process be started by producing digital educational material for Year 10 students, and introducing it as part of the education programme of Schoolchildren's Healthcare. The next step would be to develop and introduce comparable education for upper-secondary schools (students aged 16+).

It is important that staff have knowledge of risk factors, suicide-risk behaviour, and how to be supportive

of children and young people in difficulties. It is important that staff should have good knowledge of provisions that are available, so that they can direct the child/young person in the right direction as needed. Emphasis is placed upon the importance of collaboration between bodies providing services to children and young people, and of knowledge of suicide prevention being in place in all systems; and that working procedures should be clear, responses coordinated, and appropriate provisions available. It must be ensured that provisions meet the diverse needs of children and young people for support, treatment and follow-up.[45]

6. Quality control and expertise

The objective of the measures is to ensure that suicide prevention is grounded in an evidence-based approach.

Table 6: *Quality control and expertise*

Action	Purpose	Responsibility	Stakeholders	Community	Measure
6.1 Preparation of a guide on suicide risk assessment - A guide should be prepared for coordinated suicide risk assessment across all levels of health services and NGOs that work with individuals at possible risk of suicide.	That there is a guide for a coordinated assessment of suicide risk	Ministry of Health	Hospitals, health institutions, ÞÍH, Directorate of Health-Lífsbrú, NGOs	Professionals more confident in conducting suicide risk assessments.	That the guide is accessible on the internal web of ÞÍH, healthcare institutions, hospitals and NGOs as appropriate.
6.2. Coordinated suicide risk assessment - That suicide risk assessment is coordinated in all public health institutions, healthcare centres, hospitals and as many NGOs as possible that work with individuals who are potentially at risk of suicide.	Ensure consistency in evaluation, which ensures better quality, facilitates work across institutions/organisations and facilitates investigations and monitoring.	Ministry of Health	Hospitals, Healthcare Services, The Development Centre for primary healthcare in Iceland, Directorate of Health, NGOs	Professionals more confident in the implementation of ATS suicide risks, increases the quality and frequency of ATS suicide risks, which increases the likelihood that clients will receive appropriate help. Reduces the number of suicides.	Number of institutions, health care centres, hospitals and NGOs that use the coordinated suicide risk assessment according to the guide (6.1).
6.3. Coordinated registration of suicide risk assessments - That the registration of suicide risk assessments and safety plans, if applicable, in the medical records system of public institutions, is coordinated and made more accessible to professionals (e.g. with separate tabs or contact notes).	Registration of suicide risk is carried out in the same way regardless of the professional and the institution. That such registration is accessible to professionals regardless of the institution.	Directorate of Health	Ministry of Health, Landspítali University hospital	Registration of ATS suicide risks and safety plans, if applicable, in the medical records system of public institutions, is coordinated and made more accessible to professionals, e.g. with separate tabs or contact notes	Registration of suicide risk is carried out in the same way regardless of the professional and the institution. That such registration is accessible to professionals regardless of the institution.

In order to ensure quality and professionalism in services to individuals at risk of suicide and their family and friends, transparency and traceability are important at all levels of health service. This also applies to specialist NGOs which provide support to people at risk of suicide and their family and friends. With such an approach, quality and results can be evaluated, and knowledge and

understanding can be built up of assessment, treatment, prevention, and response following a suicide.

At present, record-keeping on suicide attempts, assessment of suicide risk, treatment of individuals at risk of suicide, and response after a suicide are not coordinated. It is not ensured that an individual at risk of suicide, a family member or friend, or a person bereaved by suicide will receive the same service, regardless of where in the country they live. Response may also vary according to which body provides the service. The lack of a coordinated procedure can give rise to difficulty in evaluating the scope of the problem, achieving an overview, or evaluating the results of measures. By the same token, it becomes difficult to ensure that evidence-based treatment is provided in accord with the best knowledge in the field. And this is a major hindrance to the building up of expertise on suicide in Iceland. Much remains to be done, and it is clear that it will take time to build up effective quality control and expertise in this field in Iceland. The measures proposed here are important first steps towards that objective.

Measure 6.1 is concerned with the production of guidelines on suicide risk assessment. This is a key factor in order to ensure that evidence-based methods are used in suicide risk assessment, and in order that it should be possible to build up knowledge and skills among professionals, both within and outside the healthcare service. Coordinated assessment also facilitates the sharing of information between different service levels of the healthcare system, prevents unnecessary duplication and thus saves time, work and money. It also goes to enhance service-users' confidence and trust in the system.

Coordination also facilitates continuity of service, and ensures that individuals will receive the appropriate service, regardless of where in the country they live, and regardless of their interface with the healthcare system.

Measure 6.2 is concerned with the introduction of coordinated procedures in suicide risk assessment, and their visibility at all levels of the healthcare system, and as widely as possible outside it. It is important to coordinate protocols grounded in evidence-based methods, and in order that the procedures should be practicable, it is important that it should be accessible to healthcare personnel and gatekeepers. Information must be shared across bodies in the interests of the service-users, who deserve the best available service, regardless of where they seek assistance. In 2024 funding was granted by the Ministry of Health to commence work on this measure, via the Mental Health Strategy for 2023-27.

Measures 6.3 and 6.4 aim to achieve coordinated registration of medical records: this is a prerequisite for being able to assess the scope of the problem, monitor developments, and evaluate the results of measures. Without coordinated registration it is hard to assess how many people seek healthcare service following a suicide attempt, and how many people at risk of suicide seek healthcare service. The lack of such data makes it difficult to assess the scope of the problem and the need for measures and interventions, and to evaluate their

results. It may also limit the potential for important research on the present state of affairs, and potential for improvements.

The four measures will be conducive to enhancing quality control, so that the responsible bodies can perform their tasks in a systematic manner. Further improvements may be added later, but coordinated registration and procedures, and access to guidelines, are important first steps.

7. Support for those bereaved by suicide

The objective of the measures is that those who have been bereaved by suicide should receive appropriate support.

Table 7: *Support for those bereaved by suicide*

Action	Purpose	Responsibility	Stakeholders	Community	Measure
7.1 Coordinated support following suicide outside institutions - Establish a coordinated, low-threshold national resource that provides support and follow-up for relatives and individuals affected in the immediate environment when a suicide occurs in the community, outside of public institutions.	Appropriate support is provided in the event of a suicide in the community, outside institutions.	Directorate of Health	Ministry of Health, Ministry of Children and Education, Ministry of Justice, Ministry of Social Affairs and Labour, NGOs, emergency responders, pastoral care providers, peers.	To limit the impact of trauma and loss on relatives and people in the immediate environment after suicide.	In each quarter of the country, a low-threshold resource will be in place that provides support and follow-up to relatives in the event of a suicide in the community, outside of public institutions.
7.2 Coordinated support measures following suicide within an institution - Establish a coordinated procedure to ensure appropriate support for relatives, staff and others in the immediate environment if an individual dies by suicide within a public institution, i.e. health institutions, hospitals or prisons.	Appropriate support is provided in the event of a suicide within an institution.	Directorate of Health	Ministry of Health, Ministry of Children and Education, Ministry of Justice, Ministry of Social Affairs and Labour, NGOs, emergency responders, pastoral care providers, peers.	Reduce the impact of trauma and loss on relatives and people in the immediate environment after suicide.	Proportion of health institutions, hospitals and prisons that have implemented coordinated procedures in the event of suicide.

7.3 Access to low-threshold resources for people who have lost a loved one to suicide - Ensure that individuals who have lost a loved one have access to appropriate, low-threshold support and follow-up services provided by NGOs and religious organisations. This support should be grounded in evidence-based methods.	People should be offered appropriate counselling and support after a loss og a loved one to suicide.	Ministry of Health	Directorate of Health, the Ministry of Social Affairs and Labour, the Ministry of Justice, the National Church, religious organizations, The Development Centre for primary healthcare in Iceland, health institutions, associations, pastoral care providers and peers.	People should be offered appropriate counselling and support after a loss of a loved one to suicide.	There is a low-threshold support for people who have lost a loved one to suicide There is an accessible overview of the resources available at NGOs and institutions that offer support and follow-up to people who have lost to suicide.

The concept of *postvention* is relatively new in suicide prevention theory. The measures in this chapter are concerned with enhancing support for the bereaved following a suicide, by introducing a coordinated procedure both within institutions and outside, and ensure access to appropriate low-threshold provisions for bereaved family and friends. These measures play a crucial role in suicide prevention, as each suicide is believe to affect up to 135 people in the immediate environment of the deceased.[46] In the context of Iceland, where an average of 41 people have died by suicide in each of the last five years (2019-2023),[47] this means that each year about 5,500 know someone who has died by suicide. The impact is greatest, and likely to last longer, for family members, close friends and therapists, but evidence has demonstrated the importance of speaking also to other people who knew the deceased, providing them with appropriate information on grief following a bereavement by suicide, and directing them towards provisions as necessary.[48,49]

A sudden and unforeseen death such as suicide may lead to post-traumatic stress immediately following the bereavement and may have a range of impacts on family members and friends. Grief following a suicide is sometimes termed “complicated” grief, as the grieving process is many-faceted and may be prolonged.[50,51,52] Those bereaved by suicide are at increased risk of developing depression and anxiety, and even of abuse of medications, other substances and alcohol. Research indicates that the bereaved are at increased risk for post-traumatic stress disorder, and their malaise can also lead to increased suicide risk, with higher rates of self-harm, suicide attempts and suicide.[53,54]

Support for this group is thus a necessary element of suicide prevention. It is important that the support should be appropriate, and in accord with the relationship with the deceased and the. The benefit is twofold: on the one hand, to make it easier for the bereaved to work through their grief, and on the other

to prevent potential breakdown in the bereaved person's own health, both physical and mental.[55]

Easy access to support following a suicide may mitigate the risk of further suicides in a group of friends, school, community or family of the deceased – termed *suicide contagion*. [56] Appropriate support for those affected by the death, education, and collaboration with the immediate community and media are all important following a suicide.[57]

In Iceland, studies have been carried out on the experience of people bereaved by suicide of support and provisions; unfortunately these revealed that services are limited, and not coordinated.[58,59] With a coordinated procedure both inside institutions and outside, it can be ensured that service-users have access to information on appropriate provisions and support, that the development of symptoms be monitored, and that people can be directed or referred to appropriate treatment if specialised service is required, e.g. due to mental disorder or substance abuse. It is necessary that provisions should be in place, to which a referral may be made, whether the need is for low-threshold or specialist service.

Measure 7.1 is concerned with ensuring appropriate support for people in the immediate environment of the deceased, if the suicide has taken place outside an institutional setting. Work on this measure is under way; the Ministry of Social Affairs and Labour, the Public Health Fund and other parties have provided funds to this project, undertaken by *Sorgarmiðstöð* (Grief Centre) with this objective in mind. The project has been named *Hjálp48* (Help48). This means that support will be available after a suicide or other sudden death, the objective being that first contact be within 48 hours of the death.[60] The *Hjálp48* project is managed by the Grief Centre in collaboration with *Lífsbrú* and other appropriate stakeholders.

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