Partnerships for Life European Region Summary Report

Partnerships for Life (PfL) launched its first series of workshops on national suicide prevention strategies in the European region in November 2022. Four workshops, led by Prof. Thomas Niederkrotenthaler (PfL Europe Regional Coordinator) with the support of Prof. Steve Platt (PfL Steering Committee Chair), were delivered in November 2022, February 2023, March 2023, and November 2023. Across the four workshops there were 48 partners from 25 countries that attended. The countries that presented were Armenia, Austria, Belgium, Czechia, Denmark, Estonia, France, Germany, Greece, Iceland, Ireland, Israel, Kazakhstan, Kosova, Lithuania, Moldova, Netherlands, Norway, Poland, Portugal, Romania, Serbia, Slovak Republic, Slovenia, Uzbekistan, Wales, and one autonomous Spanish region (Euskadi). A summary of each country presentation can be found below.

Representatives discussed the current status and circumstances of suicide prevention in their countries and identified challenges in developing and implementing national suicide prevention strategies. Fourteen countries have a national suicide prevention plan and/or strategy. While Belgium and Spain do not have a national plan and/or strategy, the regions Flanders (Belgium) and Euskadi (Spain) do. Common arrangements for countries without a national plan and/or strategy are phone, email, and online chat services for individuals experiencing suicidal thoughts, communicating media guidelines for responsible reporting of suicide, and to a lesser extent, psychiatric inpatient and outpatient care, and/or psychosocial therapies.

In productive and engaging group discussions, partners covered a range of topics and issues relevant to the planning, implementation, and evaluation of national suicide prevention strategies, including:

- When building the movement for national action on suicide prevention, it is important to use a strategic approach that is sensitive to the political, social, and cultural context of the country and the current level of awareness, commitment, and action relating to suicide. Both top-down (government-led) and bottom-up (community-led) approaches should be considered. If there is no acknowledgement of need at government level, a bottom-up approach may be most appropriate. Ideally, both top-down and bottom-up approaches should be pursued.

- Political support is vital to the development of coordinated national suicide prevention programmes founded on a broad public health approach. Several governmental challenges and limitations were identified, including instability and change (in political priorities, key personnel, resources) and short-term planning within government, and poor collaboration and cooperation between government departments and between government and other sectors. Prevention efforts sometimes need to depend on local community groups, NGOs, clinicians and academia to develop and implement programmes.

- Four ideas for increasing awareness at governmental level of the importance of implementing national suicide prevention programmes (where such awareness is lacking) were: (1) provide examples of other countries which can serve as benchmarks/exemplars and refer to relevant statements and policy positions by international bodies (WHO, IASP, etc); (2) undertake and submit to government a situation analysis covering data about the epidemiology of suicide and the status of suicide prevention in the country; (3) commission international suicide prevention experts to seek meetings with key government personnel (ministers and civil servants), with a view to making the case for a comprehensive, strategic approach to suicide prevention; and (4) invite key government personnel to attend PfL workshops (and other, relevant meetings) which make the case for national suicide prevention strategies and action and seek to build the political will to take suicide prevention seriously.

- Funding remains a major challenge. Problems include a lack of, or insufficient resources (including, but not confined to, budget) for implementation of strategies, and/or short-term or time-limited funding, typically linked to a specific project/programme with no guarantee of continuing financial support on a sustainable basis. Working with multi-national companies might be worth consideration.

- Data availability and quality continue to be concerns for partners. This is due to delays in publication of data, and data reliability and completeness. It was recognised that there is a tension between collecting robust data and protecting personal data, particularly in small (national or sub-national) population groups. Sound data are essential for monitoring and evaluation of national strategies, but this requirement is not always treated as a priority.

- Partners indicated that they would welcome advice and support regarding appropriate methodologies for evaluating national suicide prevention strategies.

- It was noted that two systematic reviews, currently in progress and supported by the PfL programme, would provide crucial evidence about the effectiveness of interventions typically included in national strategies and of national strategies as a whole. These reviews will be made available to PfL partners and used to strengthen the quality and impact of national strategies on suicide-related outcomes.

- It was acknowledged that national suicide prevention strategies need to address macro-level factors ('social determinants' such as poverty) because of their known impact on the incidence of suicide. However, it was also noted that achieving a positive impact on social determinants of suicide is extremely challenging, since it requires the promotion of a protective social, political,

cultural, economic, and physical environment through government action. The appropriate conditions for, and the will to effect positive change in, the social determinants are often absent.

- Terminology and language were noted as a barrier. Partners identified the lack of a consensus on what constitutes a suicide prevention "programme" or "strategy." Partners argued that definitions of these and other key terms should be agreed, and a standardised nomenclature developed for the PfL programme.

- Partners argued that peer-to-peer support and mentorship (between countries at different stages of developing suicide prevention strategies) can play a valuable role, and should be encouraged, within the PfL programme. They also highlighted the importance of recognising and considering specific cultural contexts and sensitivities when undertaking cross-national collaboration. There is an ongoing debate about whether it is more productive to bring together countries at a similar stage of national strategy development or countries at different stages. Both types of interaction have advantages and should be considered, depending on the purpose of the meeting.

- Partners discussed the importance of sharing expertise and learnings, and identification of useful resources and tools, in connection with the implementation and evaluation of national strategies. The proposed PfL webinar programme is intended to promote these objectives.

- Partners proposed the establishment of networks of experts on a regional or sub-regional basis. To that end, a directory of areas of expertise would be valuable. This initiative would be consistent with the move to establish sub-regional groups within the PfL European region, each led by a coordinator who would belong to an over-arching European Steering Group.

Armenia

Armenia age-standardised suicide rates per 100,000 (2019)[1] people:

- Both sexes: 2.7
- Female: 1.0
- Male: 4.9

Dr Aram Mamikonyan contributed to the presentation. There is not an established specific suicide prevention strategy in Armenia yet. Although currently, a group of specialists who work with the Ministry of Health of Armenia are collaborating to develop a national suicide prevention plan.

The field of suicide prevention is challenging. There are few researchers in the field, so it is quite difficult to determine and understand the current challenges. I would mention the "basics" - reliable statistics that can indicate the specificities of suicide behaviour in Armenia - to target in prevention strategies.

Every year the Statistical Committee of the Republic of Armenia publishes statistics of identified suicide attempts and suicide deaths. The proportion of the cases among age and gender groups, proportions associated with people's social status and common methods of suicides are included there. The data of the Statistical Committee of the Republic of Armenia is based on the Police Information Centre. Also, the National Institute of Health publishes the Health and Healthcare Statistical Yearbook that includes the number of suicide deaths, the proportion associated with mental disorders, gender, and age. Data is provided by the Health Ministry. Notably, data provided by both the Statistical Committee of the Republic of Armenia and The National Institute of Health doesn't match on many points. The ratio of suicide death is low in Armenia according to official statistics. However, this is not exactly reliable.

[1] Suicide rate statistics for each country (unless noted otherwise) are derived from: World Health Organization. (2019). *Suicide rates estimates, age-standardised estimates by country*.
https://apps.who.int/gho/data/view.main.MHSUICIDEASDRv?lang=en
Please note: Globally, the availability and quality of data on suicide and suicide attempts is poor. Therefore, caution should be applied when interpreting national suicide rates.

Austria

Austria age-standardised suicide rates per 100,000 (2019) people:

- Both sexes: 10.4
- Female: 4.6
- Male: 16.6

Mag. Alexander Grabenhofer-Eggerth and Mag. Michaela Pichler, and Mag. Mag. Beate Gruber contributed to the presentation, with Joy Ladurner focusing on the Implemental program. The Austrian national suicide prevention program SUPRA (SUizidPRävention Austria) was launched in 2012, with an implementation concept developed together with a panel of around 30 experts (BMASGK, 2019). The structuring of the implementation concept was based on the recommendations of the World Health Organisation (WHO; 2012, 2014), and adapted for Austrian circumstances.

The concept consists of six pillars of suicide prevention, 18 operational goals, and 70+ measures to achieve the plan was defined (BMASGK, 2019). For each measure, the responsibility of implementation, measurement, and target value were described. The measures refer to universal, selective, and indicated preventions. To overcome perceived barriers to implementation and make this rather demanding concept "digestible" for decision-makers, a "starting package for suicide prevention" was extracted from it, containing one or two measures for each of the six pillars that can be implemented relatively quickly (within 1-3 years). This structured and - as far as possible - scientific evidence-based approach already led to SUPRA's first international award as a model of good practice in 2017 (EU Compass Consortium, 2017).

Further, SUPRA was selected in 2019/20 as a European best practice example designated for roll-out via Joint Action. Suicide prevention based on the example of SUPRA represents one of two technical work packages of the EU Joint Action ImpleMENTAL (https://ja-implemental.eu), along with the Belgian mental health care reform. The aim of this Joint Action is to implement best-practice models in other EU countries. However, it is not a question of a 1:1 copy, but rather of implementations adapted to national and regional situations in each case.
Suicide prevention in Austria benefits from the Joint Action ImpleMENTAL in two ways: On the one hand, the selection as an international flagship project opens doors in Austria that seemed closed for a long time (e.g., increased funding of crisis intervention services, gatekeeper trainings, and national crisis hotline). On the other hand, the intensive international exchange brings new expertise and experience to Austria.

Belgium

Belgium age-standardised suicide rates per 100,000 (2019) people:

- Both sexes: 13.9
- Female: 8.4
- Male: 19.6

Prof. Gwendolyn Portzky and Kirsten Pauwels contributed to the presentation. Suicide prevention in Belgium is complex because Belgium is a federal state, but prevention is a responsibility of the regions (Flanders, Wallonia, and the German-speaking part of Belgium). In Wallonia and the German-speaking part of Belgium, there is no structural suicide prevention provided by governments.

In Flanders, however, there has been a suicide prevention policy for almost two decades. The first Flemish suicide prevention plan and subsequent evaluation (2006-2010) guided the development of the 2012-2020 plan. This second plan was based on five strategies:

1. Mental health promotion in relation to the individual and society.
2. Suicide prevention through accessible telephone and online help.
3. Promoting expertise and networking among intermediaries.
4. Strategies for specific risk groups.
5. The development and implementation of recommendations and tools for suicide prevention.

The 2012-2020 plan aimed to reduce the suicide rate in Flanders by 20%. This measured by comparing the suicide rate at the end of 2020 with the 2000 rate. Encouragingly, this aim was achieved as the suicide rate decreased 28.8% (28.6% in Males; 29.7% in Females). An evaluation highlighted that a large amount of suicide prevention actions had been effective and thus needed to be continued. Yet, new needs and gaps in the plan were detected. This resulted in the development of the third Flemish Suicide Prevention Plan (2022-2030). The new target is to decrease the suicide rate by 10% in 2030 when compared to the 2020 rate. This third plan is based on 6 prevention strategies that can be seen in the image below.

Despite these successes over two decades of suicide prevention in Flanders, a key challenge is the broad implementation of the large set of strategies and actions. It is hoped that continued finance from the Flemish Government through three organisations (VLESP [Flemish Centre of Expertise in Suicide Prevention responsible for development and implementation of evidence-based suicide prevention actions], CPZ [responsible for the suicide helpline and training], and CGG-SP [training of professionals and gatekeepers]), can help towards overcoming implementation barrier(s).


Gezondheidsconferentie
Suïcidepreventie 2021
3e Vlaams Actieplan Suïcidepreventie (2022-2030)
Voorstel
Gezondheidsdoelstelling
DE STERFTE DOOR ZELFDODING
TUSSEN 2020 EN 2030 VERMINDEREN MET
10%
SAMEN KUNNEN
WE ZELFDODING
VOORKOMEN
De 6 strategieën
1 Suïcidepreventie bij de hele bevolking
2 Deskundigheidsbevordering bij professionelen en sleutelfiguren
3 Suïcidepreventie bij kwetsbare groepen
4 Preventie bij suïcidale personen & ondersteuning naasten
5 Postventie na suïcide & ondersteuning nabestaanden
6 Onderzoek, monitoring cijfers & evaluatie actieplan
AGENTSCHAP
ZORG & GEZONDHEID
VLESP
Vlaams
Expertisecentrum
Suïcidepreventie

Czechia

Czechia age-standardised suicide rates per 100,000 (2019)[2]:

- Both sexes: 11.2
- Female: 4.4
- Male: 19.0

Dr Alexandr Kasal, Dr Petr Winkler and Mgr. Roksana Táborská contributed to the presentation and provided more recent suicide rates per 100,000 from The European Population Standard for 2020: both sexes: 11.4, Female: 3.9 , Male: 20.4 and for 2021: both sexes: 11.6, Female: 4.8, Male: 19.7[2].

The Czechia government adopted the 2020-2030 National Action Plan for Suicide Prevention (NAPSP) that was developed by the National Institute of Mental Health (NIMH). The NAPSP and National Action Plan for Mental Health are guiding documents for suicide prevention efforts, while Health Care Department at the Ministry of Health and National Council for Mental Health are key stakeholders. The National Council should inform about the implementation and changes. Activities are mostly coordinated and monitored by small group of researchers/public health experts/practitioners focusing on suicide prevention and research as a part of Public Mental Health Research Program, while collaborating with the Czechia Ministry of Health.

The first website dedicated to suicide prevention was launched in 2022, and currently provides live chat crisis consultation. However, there is no telephone hotline dedicated solely to suicide prevention, but several hotlines for the public and specific populations (e.g., youth, elderly). Czechia currently takes part in the EU project Joint Action ImpleMENTAL which includes creation of an action plan. Our expected outcomes are revision of existing strategy and package of measures for suicide prevention on railways as education of railway personnel, identifying and securing hotspots and making postvention for railway personnel available.

Several other activities from NAPSP are currently being considered for piloting from 2024 onwards. Implementation project is now being formulated including following activities:

1. Support groups for individuals bereaved by suicide.
2. Ensuring continuity of care after hospitalisation in psychiatric hospital.
3. Education and awareness raising activities among several target groups (e.g., general practitioners, teachers, public).

[2] Note: The European population standard, published by Eurostat in 2013 (source https://ec.europa.eu/eurostat/en/web/products-manuals-and-guidelines/-/KS-RA-13-028).

Denmark

Denmark age-standardised suicide rates per 100,000 (2019) people:

- Both sexes: 7.6
- Female: 4.2
- Male: 11.1

Assoc. Prof. Annette Erlangsen and Dr Trine Madsen contributed to the presentation. Denmark does not have a national plan and/or strategy for suicide prevention despite universal public health care, including care of mental health is available for all people who live in Denmark free of charge. That said, there is a national suicide prevention partnership led by the Danish Medicines Agency. Partners include clinicians from the Danish Suicide Prevention Clinics, the Danish Helpline for suicide prevention, researchers, NGOs, and representatives from ministries, regions, and municipalities. This partnership meets twice each year to discuss relevant topics and initiatives for advancing suicide prevention. Danish Medicines Agency is currently working on a draft for a national plan, which still needs to be passed by the national parliament.

Despite no national plan for suicide prevention, there are efforts aimed at reducing the suicide rate. Suicide Prevention Clinics offer free psychosocial therapy in out-patient settings to individuals with severe suicide thoughts or after a suicide attempt. There is also a helpline (and chat and text) operated by an NGO ("Livslinien") that helps individuals with suicidal thoughts. The same helpline also offers online therapy for people with suicide thoughts (program developed by A Kerkhof). Further, pack size restrictions on paracetamol and other weak painkillers were enacted in 2013, with encouraging results.

Estonia

Estonia age-standardised suicide rates per 100,000 (2023)[3] people:

- Both sexes: 14.0
- Female: 6.7
- Male: 24.2

Dr Zrinka Laido contributed to the presentation. To gain a comprehensive understanding of the evolving suicide prevention efforts in Estonia, it is crucial to delve into the historical transformations that have shaped this Baltic nation socially, economically, and politically. Suicide data for Estonia became accessible only in the late 1980s, revealing a consistently high suicide rate fluctuating between 33 to 35 per 100,000 inhabitants at that time. Despite persistently exceeding the European average in suicide mortality rates, Estonia has witnessed a declining trend in suicide rates throughout the 21st century. However, over the past decade, this downward trend has shown stagnation, with an annual suicide count hovering around 200 cases.

The Estonian government has consistently demonstrated a commitment to prioritising mental health, although these efforts have encountered challenges in terms of sustainability. In 2015, the Ministry of Social Affairs called upon NGOs active in the mental health area to join and establish an umbrella organisation advocating for mental health and those in need. The Coalition for Mental Health and Well-Being (VATEK) has since become a strong strategic partner for the government and a champion for mental health in the public eye. A noteworthy turning point occurred with the government's approval of the Green Paper on Mental Health in April 2021, signalling a shift towards recognising and prioritising mental health. Moreover, the impact of the COVID-19 pandemic heightened awareness around mental health, prompting the establishment of the Mental Health Department within the Ministry of Social Affairs (MoSA) in early 2022. This strategic move underscores the government's responsiveness to the evolving needs of its citizens in the face of unprecedented challenges. In a collaborative effort with various stakeholders, the Ministry of Social Affairs has diligently crafted the Mental Health Action Plan (2023–2026). This comprehensive plan not only underscores the broader spectrum of mental health concerns but also includes a dedicated segment specifically addressing suicide prevention. The concerted focus on mental health, particularly suicide prevention, within this strategic framework signifies a holistic approach and a proactive stance towards safeguarding the well-being of the Estonian population.

In recent decades, **suicide prevention efforts** in Estonia have taken a multifaceted approach, encompassing activities aimed at integrating suicide awareness into society and enhancing knowledge about suicide. Initiatives include establishing crisis hotlines, implementing measures to restrict access to

[3] Statistics Estonia. Deaths per 100 000 inhabitants by cause of death, sex and age group [Internet]. 2023 [cited 2023 November 06]. Available from: SD22: Surmad 100 000 elaniku kohta põhjuse, soo ja vanuserühma järgi. PxWeb (tai.ee)

means, providing in-person psychosocial and psychiatric crisis services, and advocating for responsible media reporting. The government actively collaborates with NGOs and mental health advocates, recognising their indispensable role in offering support, outreach, and education to the community. Estonia boasts a robust NGO community dedicated to suicide prevention, with a longstanding tradition of research facilitated by the Estonian-Swedish Mental Health and Suicidology Institute (ERSI), established in 1993. ERSI has made significant contributions to suicide education and awareness, international research, practical assistance (such as establishing the first helpline), and networking on the international stage, collaborating with organizations like WHO and the EC. In 2023, a noteworthy development occurred with the formation of the Estonian Association of Bereaved as a separate association, adding another dimension to the comprehensive efforts in addressing the aftermath of suicide. This establishment further highlights Estonia's commitment to holistic mental health care. Another pivotal player in suicide prevention is the NGO "Peaasjad", which actively promotes mental health and early intervention by disseminating information on suicidality, offering crisis intervention, facilitating essential services, and monitoring media reports to react promptly when necessary. Other mental health advocates also make significant contributions to suicide prevention in the country. These collaborative efforts underscore Estonia's commitment to addressing mental health challenges and fostering a supportive environment for its community.

When it comes to supporting and treating individuals exhibiting suicidal behaviour or intent, Estonia offers a range of accessible services. The country has established **nationwide crisis support hotlines** that operate 24/7, catering separately to adults and minors. These hotlines include both phone helplines and online chats, with the Social Insurance Board overseeing their administration. While the crisis lines cover various aspects of crisis intervention, there is currently no dedicated hotline specifically tailored to suicide prevention. Additionally, in several larger cities, namely Tallinn, Tartu, Viljandi, and Pärnu, in-person psychosocial and psychiatric crisis services are available around the clock for patients of all ages. However, the provision of follow-up care after an emergency contact, lacks standardisation and consistent practice.

Training for gatekeepers in settings such as educational institutions and general practitioners is provided periodically, contingent upon available funds from different projects. It is noteworthy that these training sessions, while beneficial, tend to focus more broadly on mental illness topics, such as depression, rather than exclusively on suicide prevention**.**

In terms of means restriction, Estonia has established standards for weapon security and norms for the regulation of prescription practices. Additionally, there are limitations in place for alcohol sales, contributing to efforts in suicide prevention. Concerning structural measures, some places have preventive restrictions to reduce the risk of falls from height, although the application of such measures are not systematically implemented across all areas.

In relation to **responsible media reporting on suicide**, there have been recent notable developments in Estonia, reflecting increased efforts in the country. In September 2023, Estonia took a significant step forward by introducing the Papageno Award, designed to commend journalists who responsibly report on suicidal behaviour. This initiative was a collaborative effort between the Ministry of Social Affairs and the Estonian Association of Young Journalists (ENAS). Building on previous endeavours to promote responsible media reporting, Estonia translated WHO guidelines on the subject and engaged in monitoring the quality of media reports, taking action when necessary. While not yet fully integrated, there is ongoing development in the form of an online course on responsible media reporting. This course has been created by the Estonian WHO Liaison office in collaboration with international experts, primarily targeting journalism students. In 2021, Estonia joined the EU Commission Initiative, Joint Action ImpleMENTAL (JA-impleMENTAL), which obliges the country to develop a **Suicide Prevention Strategy** by September 2024. This ongoing commitment reflects Estonia´s dedication to addressing the complex issue of suicide and fostering mental well-being in its population.

France

France age-standardised suicide rates per 100,000 (2019) people:

- Both sexes: 9.7
- Female: 4.5
- Male: 15.2

Prof. Fabrice Jollant and Dr Charles-Edouard Notredame contributed to the presentation. The first national suicide prevention strategy was launched in 2018, initially in the general framework of a "*Mental health and psychiatry roadmap*" and in a more individualised manner since 2022. This strategy, funded and steered by the Ministry of Health and implemented by the Regional Health Agencies, was based on previous field experiences and research (Vaiva et al., 2006). The French national strategy currently comprises five pillars:

1. A two-day national training course for health professionals on suicidal risk identification and crisis intervention. Implementation of gatekeepers is also organised.
2. Post-suicide attempt monitoring, and brief phone contact intervention system (VigilanS) aimed at reducing the risk of re-attempts.
3. A national professional helpline (3114) set up in October 2021 and open 24/7 to people suffering, the people close to them, and health professionals. The helpline provides initial support, counselling, and local orientation for care.
4. A training program in suicide ethical communication (Papageno) aimed at limiting suicide contagion effects.
5. Various public information programs conducted by Public Health France.

Additional actions to reinforce the prevention or suicide contagion (e.g., national implementation of postvention plans, elaboration of a toolkit to prevent hotspots, digital prevention actions), are in preparation. Various particularities and difficulties have been highlighted. These include:

- A centralised, hierarchical, and administrative management.
- Difficulty in mobilising and articulating many mental health professionals.
- Variable territorial anchoring of the pillars.
- Interest in the gatekeeper program from various stakeholders without a necessary long-term plan for supervision.
- Difficulty in evaluating the effectiveness of the strategy due to unreliable indicators to date.
- A lack of assessment of long-term effect of training.
- A lack of external auditing to assess the global consistency of the strategy.
- A current decline in the supply of mental health care combined with a growing demand, which may impact many above-cited interventions.

Germany

Germany age-standardised suicide rates per 100,000 people (2019):

- Both sexes: 8.3
- Female: 3.9
- Male: 12.8

Dr Barbara Schneider and Dr Reinhard Lindner contributed to the presentation. The current National Suicide Prevention Program (NaSPro) was founded in 2001 by the German Association for Suicide Prevention (DGS) to promote and develop suicide prevention. The NaSPro is a non-governmental network of specialists in suicidology and suicide prevention working together with a mostly bottom-up strategy with various groups of national organisations, institutions, and activities to promote suicide prevention in the specific fields. More than ten specific working groups (with subgroups) with about 150 experts are encouraging and promoting the work in different fields, e.g., media and public communication, elderly, children and adolescents, health services, means restrictions, networks of suicide prevention.

There are five fundamental principles that underpin the overall principle that anyone seeking help should be able to find qualified help quickly and without complications. The fundamental principles are:

- Suicide prevention is possible.
- Suicidality is a complex phenomenon.
- Suicide prevention is a social task.
- Suicide prevention is necessary on different levels.
- Suicide prevention must involve the relatives and other persons affected.

At least four of the WHO's six conditions of “good” suicide prevention (Live Life, 2021) are being fulfilled by NaSPro:

1. Situation analysis through the development of a comprehensive report on suicide prevention in Germany (https://www.naspro.de/dl/Suizidpraevention-Deutschland-2021.pdf)
2. Multisectoral collaboration by activating a variety of intervention areas, professions, and scientific disciplines.
3. Raising awareness and advocacy for change through media work and public relations, expanding cooperation and policy statement initiatives in the political area.
4. Capacity building
5. Financing
6. Monitoring and evaluation.

Notably, the suicide rate is not considered the central criterion of success of suicide prevention because of the many influencing factors. Instead, effectiveness is shown by:

- The spread of commitment to suicide prevention in society and politics (range), the increase of information materials and their demand, participation in the World Day of Suicide Prevention etc., the increasing consideration of the topic in various professional societies.
- The increasing spread of explicit suicide prevention services and community networks.
- Increased cooperation and requests from the media about reporting problems.
- More scientific papers and projects on suicide.
- The 2017 Bundestag resolution on the importance of suicide prevention and associated research funding of €5 million.
- The current broad support for a legally anchored financial regular promotion of suicide prevention and associated with this, a motion in the Bundestag across the parliamentary groups (decisions expected in 2023) (https://www.koordinierung-hospiz-palliativ.de/files/dokumente/220620_Eckpunkte_fuer_gesetzliche_Verankerung_Suizidpr%C3%A4vention.pdf).
- The recent 2023 Bundestag resolution on the development of a National Suicide Prevention Strategy being presented in parliament in July 2024.
- The 2023 development of a National Suicide Prevention Strategy, ordered by the Federal Appropriation Committee by the Federal Ministry of Health supported by NaSPro.

Three key barriers to improvements in suicide prevention were noted:
1. The attitude of professionals in the healthcare system is that suicidality is an exclusive problem of psychiatric illnesses (especially depression); suicide prevention should only focus on the illness.
2. The largely only project-oriented promotion of suicide prevention measures and institutions with time-limited funding.
3. The liberalisation of assisted suicide, the non-evidence-based marketing of the offer of assisted suicide as effective in suicide prevention and a related public relations campaign that denotes suicide as a freely responsible expression of self-determination, combined with the psychiatrisation of suicides without assistance as "affect suicides."

Greece

Greece age-standardised suicide rates per 100,000 (2019) people:

- Both sexes: 3.6
- Female: 1.5
- Male: 5.9

Dr Katarina Kavalidou and Assistant Prof. Konstantinos Kotsis contributed to the presentation. Greece does not have a national suicide prevention plan and/or strategy. Since 2012, Athens has a day centre for suicide prevention (healthcare service), including a 24/7 suicide helpline (1018), and email contact for suicide-related help (help@suicide-help.gr). This is operated by an NGO (Klimaka), partly funded by the Ministry of Health.

The most recent Mental Health Strategy/Plan 2021-2030 that was presented in the parliament (by the Greek Deputy Minister for Mental Health Mrs Rapti), does not include any type of suicide prevention policies. However, the Mental Health Strategy/Plan acknowledges the lack of prevention strategies and proposes several items that should be carried out: a national plan for suicide prevention; assembling a committee to monitor suicidal outcomes; and create campaigns for suicide awareness addressed to the general population (further focusing on preventing depression).

Current work in Greece lead by Dr Kavalidou and Assistant Prof. Kotsis includes:

- Gathering information on Greek organisations that have ever submitted a suicide prevention strategy at a national or/and regional level. A key aim is to bring together organisations that have submitted a proposal, to work together in submitting a new joint suicide prevention strategy proposal.
- Initiating a brief policy paper with Greek academics that have previously investigated suicide and/or suicidal behaviour. Once published, this study will be used in the new proposal developed for the above.
- Conducting a research study on 'Reporting of suicide and self-harm in Greek online media: a comparison against World Health Organisation guidelines'. Findings and recommendations of this study will be communicated to the Journalists' Union of Athens Daily Newspapers and Greek university departments of journalism and media studies.

Iceland

Iceland age-standardised suicide rates per 100,000 (2019) people:

- Both sexes: 11.2
- Female: 3.5
- Male: 18.7

Gudrun Jona Gudlausdottir and Kristin Olafsdottir contributed to the presentation and provided more recent suicide rates from the Office of the National Medical Examiner for 2020: Both sexes: 12.8, Female: 8.4, Male: 17.0, and 2021: both sexes: 10.2, Female: 6.6, Male: 13.6.

Iceland has a government approved and funded suicide prevention plan that started in 2018. The plan reflects a life-course, whole-of-society approach to suicide prevention that includes 54 actions, permeating every sector of Icelandic society. Iceland is also a participant in the Joint Action ImpleMENTAL project (https://ja-implemental.eu/participants-2/) based on Austria's "best practice" SUPRA. There is one nationwide database for all suicides in Iceland. This database is based on a forensic autopsy of every suicide. Suicide statistics can be accessed (in English) via this link: https://www.landlaeknir.is/tolfraedi-og-rannsoknir/tolfraedi/danarorsakir/sjalfsvig/

Currently, the main challenge in suicide prevention are the limited financial resources allocated to this project. There is a plan in progress to solve this.

Ireland

Ireland age-standardised suicide rates per 100,000 (2019) people:

- Both sexes: 8.9
- Female: 3.6
- Male: 14.3

John Meehan, Dr Philip Dodd, and Sarah Woods contributed to the presentation. Suicide prevention in Ireland was advanced by the Reach Out, the Irish National Strategy for Action on Suicide Prevention, 2009-2014. It laid the foundations for a collaborative, multidisciplinary, community-focused approach to suicide prevention. This was reflected in the second and current national strategy for suicide prevention, Connecting for Life (Department of Health, 2015). The HSE NOSP (in Irish Health Services) is the agency tasked with overseeing the implementation of Connecting for Life. There were two primary outcomes for the strategy:

1. Reduced suicide rates among priority groups and a general reduction of 10% in suicide rates in the general population by 2020.
2. Reduced self-harm presentations among priority groups and the general population.

The National Cross Sectoral Steering and Implementation Group that is chaired by the Department of Health oversees the implementation of the strategy. This group meets quarterly, with monitoring reports produced (and published) to assess implementation progress. High-level political leadership is provided at the Cabinet Committee level, allowing for a uniquely centralised oversight of the strategy. This tiered leadership at all levels of the policy system is helpful to communicate the importance of a public health approach to suicide prevention and provide ongoing feedback from the system on implementation as it happens. At a local county level, there are additional local cross-sectoral groups established which have developed ten local plans aligned to the national strategy.

Mid-way through implementation, an independent interim review on the implementation of the strategy was conducted. It concluded that some progress was evident across all seven goals, with good progress highlighted in many strategic areas, but limited progress in others. The review informed the areas for renewed focus or suggested refined approaches in national and local implementation plans. In 2020, the Connecting for Life was extended to 2024. This provided an opportunity to further advance and embed already-established local implementation structures throughout the country.

Presently, the HSE NOSP is formulating a new implementation plan for the current period (2023 - 2024) and planning for an overarching evaluation of success and implementation of the strategy since 2015.

Israel

Israel age-standardised suicide rates per 100,000 (2019) people:

- Both sexes: 5.2
- Female: 2.1
- Male: 8.3

Prof. Alan Apter and Prof. Anat Brunstein-Klomek contributed to the presentation. The national plan for suicide prevention in Israel is underpinned by a 2013 government resolution that aims to reduce suicides and suicide attempts and assist families whose loved ones have died by suicide. The program is implemented under the leadership of the Ministry of Health; partners are the Ministries of Education, Social Affairs, Aliyah and Immigrant Absorption, Social Equality, Public Security, the Local Authorities, the Police, the IDF, Prison Service, associations, academies, and other various partners. In each city and organisation, a steering committee is established building a working plan, including trainings, chain of care and treatment options.

There are seven strategies within the national plan, each at different stages of implementation. These include:

1. Public education to increase awareness on suicide and its prevention. Approximately 170 cities started implementation.
2. Epidemiology and data improvement to establish a reliable data base. The Center of Disease inspected thousands of deaths reports and a cause of death controller development in progress.
3. Training gate keepers (more than 55,000 individuals trained across education, health, government, academia, etc.) and professional training that includes thousands of school psychologists trained in screening and risk assessment. In addition, training for hundreds of therapists in health organisations.
4. Treatment continuum activities to ensure access to treatment in a variety of languages and cultural adaptations. Currently, hundreds of chains of care built in cities and organisations with ongoing improvement efforts.
5. Hot lines, such as phone and on-line support 24/7 that have witnessed increases in calls related to mental distress and suicide. Further, a unique national call center established to provide professional responses to harm and crime aimed at children in cyberspace.
6. Postvention assistance to families of suicide survivors. Eight support centers were established in addition to 120 family and couple support centers by the Ministry of Welfare.
7. Limiting access to lethal means and hotspots. Two new questions about suicidal risk were added to the questionnaire that assesses the fitness to carry a weapon, distribution of a survey to locate hotspots in local authorities, and pharmacists' collaboration in reduction of access to medicines.

Additional projects include:

1. Development of an online suicide risk assessment questionnaire.

2. Support groups for caregivers whose patient died by suicide.

Projects in the field of raising awareness which are in progress:

1. An awareness campaign to prevent suicide among males.
2. A television series on the Ethiopian channel on mental health and suicide among members of the Ethiopian community.
3. An app for risk assessment.

Kazakhstan

Kazakhstan age-standardised suicide rates per 100,000 (2019) people:

- Both sexes: 18.1
- Female: 6.9
- Male: 30.9

Symbat Abdrakhmanova contributed to the presentation. To implement the project prevention of suicide joint order of the Ministry of Health, Ministry of Education and Science and the Ministry of Internal Affairs "On the Staged Implementation of The Project for the Prevention of Suicide Among Minors in Kazakhstan" was issued in February 2015. The program was implemented in pilot mode only in the Kzylorda region initially but is now being implemented throughout the republic.

The project included the following components:

a) Identification of adolescents at risk for suicide and mental health problems with referral to health and mental health workers.
b) Gatekeeper training for school staff.
c) Awareness raising intervention for adolescents.
d) Building capacity of health and mental health services for management of adolescents at risk for suicide and mental health problems.

Identification of pupils at risk for suicide and mental health problems.

This intervention was aimed at:

- Identifying adolescents at-risk of mental health problems and/or suicidal behaviour.
- Performing a thorough assessment of mental health of these at-risk adolescents.
- Referring them to appropriate treatments, if needed.

Gatekeeper training for school staff.

Gatekeeper training was used to train teachers and other school personnel to recognise the risk of suicidal behaviour in pupils and to enhance their communication skills to motivate and help pupils at risk of suicide to seek professional care. Training materials included standard power point presentations and a booklet distributed to all trainees and including contact information for distribution to pupils identified by them as being at risk.

The gatekeeper's programme was aimed at:

- Increasing mental health literacy and awareness about suicidal behaviour.
- Fighting stigma and prejudices.
- Learning how to recognise students at-risk for suicide.
- Learning how to appropriately communicate with a student at-risk for suicide.
- Learning how to intervene and how to refer a student who is potentially suicidal.
- Providing information on how to get help.

Awareness raising intervention for adolescents

The awareness raising intervention for adolescents was aimed at:

- Increasing mental health literacy and awareness about suicidal behaviour.
- Fighting stigma and prejudices.
- Promoting the development of problem-solving skills and emotional and social intelligence.
- Promoting help seeking behaviours.
- Helping teens identifying at-risk peers and take responsible action.
- Providing information on how to get help.

The programme is based on a multimodal approach including lectures and discussions, information booklet, and posters. A trained school psychologist held three awareness raising lectures based on a standardised Power-Point presentation to pupils divided in classes.

Pupil referrals in each intervention

During and after the project interventions, students at risk are actively referred to local health-care facilities. Students are referred by psychologists, teachers and school staff, pupils self-refer, and healthcare professionals also refer the pupils (GP to psychiatrist).

Outcome measures

Outcome variables that are assessed in the project include well-being, depression, anxiety, emotional and conduct problems, coping, self-destructive and addictive behaviours, values, and lifestyles. Another outcome variable is pupil referrals, i.e., the total number of referrals inclusive all emergency cases identified during the baseline evaluation, and treatment outcomes.

Capacity building of school psychologists, mental health workers, and primary health workers

All the school psychologists who were involved in the project received a specific and standardised training on how to conduct each component. Since it was expected that these interventions would increase the help seeking behaviours of adolescents and the demand for mental health care, a capacity building training for mental health workers has been delivered and it was aimed at increasing their competences in assessing and treating adolescents with mental health problems and suicidal risk.

Primary health care is a privileged setting where identifying, and in some cases also treating adolescents with mental health needs. For this reason, primary health workers also attended a specific training on how to recognise, assess, and treat adolescents with psychological problems and at risk for suicide.

Kosova

There are no available data on Kosova suicide rates.

Sir Bind Skeja contributed to the presentation. There has never been a national suicide prevention strategy in Kosova. Further, no institutional services that seek to prevent suicide exist. Part of this passivity is brought on by the fact that there has not yet been a concerted effort to collect accurate data on suicide statistics, with the only public source being in the field police reports. These statistics are potentially inaccurate due to misclassification of deaths. For example, classifying suicide by overdose only as death by overdose, and not suicide. Therefore, the statistics may be somewhat unreliable, but also portray a significantly better situation than reality. Thus, new funds are not made available to analyse and understand the situation.

Unfortunately, there is also a lack of understanding by public mental health professionals when it comes to suicide prevention. That is, many believe that coercive treatment in psychiatric clinics is adequate as a form of prevention and rehabilitation. However, our own reports show that these services are rife with human rights abuses, oftentimes breaking patient's rights laws with impunity.

Qendra për Informim dhe Përmirësim Social (QIPS) is the only organisation (that we are aware of) working in the field of suicide prevention. We manage the only suicide prevention lifeline in the country. Further, we are pushing for political change on a national level to recognise suicide as a serious issue and to begin drafting a national strategy for suicide prevention. We also organise remembrance activities, workshops, and awareness campaigns. Our future efforts seek to shift to a more community-based vision, seeking to implement initiatives which have a long-lasting impact on individuals with thoughts of suicide (e.g., housing, employment, communal activism, etc.). QIPS is a grassroots organisation with limited funding, as such we heavily rely on volunteers willing to contribute to the cause.

Lithuania

Lithuania age-standardised suicide rates per 100,000 (2019) people:

- Both sexes: 20.2
- Female: 6.2
- Male: 36.1

Prof. Paulius Skruibis and Ms Simona Bieliūnė contributed to the presentation. The national suicide prevention action plan for 2020-2024 is coordinated by the Ministry of Health of Lithuania. There are also action plans in some municipalities, for example in the two biggest cities: Vilnius and Kaunas. Still, research completed by suicide research centre at Vilnius University indicated that suicide prevention on the national level doesn't have a significant impact on suicide rates (https://www.fsf.vu.lt/psichologijos-institutas/psichologijos-instituto- struktura/centrai/suicidologijos-tyrim-centras#savizudybiu-prevencijos-sistemos- veiksmingumo-tyrimas-savivaldybese).

The key suicide prevention initiatives include:

- Standardised gatekeeper training at the national level: ASIST and safeTALK.
- Collaborative Assessment and Management of Suicidality (CAMS) training for mental health professionals (CAMS manual translated into Lithuanian and available online).
- Regulations on the help suicidal people must receive in health care institutions approved by the Ministry of Health.
- Restrictions on reporting suicide in mass media included in the laws.
- Attempted suicide short intervention program, dialectical behaviour therapy, and mindfulness-based therapy are piloted in some mental health care institutions.
- Alcohol availability restrictions were enacted during the last decade and some of them (significant increase of VAT for beer and wine) had some positive effect on suicide rate (https://doi.org/10.1080/13811118.2021.1999873).

The biggest gap in suicide prevention is a lack of long-term support for suicidal people. On one end of the scale are general and short interventions that are available in primary health care settings. At the other end of the scale there are mental health hospitals. But there's little support in between them.

Republic of Moldova

R. Moldova age-standardised suicide rates per 100,000 (2019) people:

- Both sexes: 12.2
- Female: 3.3
- Male: 22.1

Liuba Ceban contributed to the presentation and Cristina Doroftei attended the workshop.

In 2012, when Altruism NGO organised the first public event dedicated to World Suicide Prevention Day, the Ministry of Health created a National Plan with intersectoral actions in the area. This approach continues to be helpful today. National Plans developed every five years in areas such as mental health, human trafficking, women rights, and violence prevention, occasionally incorporate suicide prevention actions.

In 2013, because of Altruism NGO lobbying, the National Child Protection Council organised research on child suicide in R. Moldova and several laws introduced child protection in the media and against negative information.

In 2017, the Moldovan Parliament passed a report on suicide in R. Moldova, following an outbreak of the Blue Whale game[4] in the country. Each governmental institution had to present a document with actions relating to suicide prevention. The Parliamentary Committee report is littered with cliche and inadmissible terms for suicide-prevention-friendly legislation. The report can be found here https://www.parlament.md/LegislationDocument.aspx?Id=a8e29865-f1fb-469f-a2fe-08aaa97131c7

Altruism NGO withdrew from supporting the report as it was driven by the Blue Whale game public popularity, rather than strategic intent to approach suicide prevention consequently.

The Altruism NGO organises lobby actions at a national level, the organisation of public events, communication with public figures, and participation in television and radio broadcasts to advocate for suicide prevention policy at national level (e.g., government ministries such as the Ministry of Health, Ministry of Education and Research, and Ministry of Labour and Social Protection). Unfortunately, a strategic approach to suicide prevention continues to elude R. Moldova.

In the Republic of Moldova, there are several laws that indirectly address the issue of suicide and its prevention. For example:

1. Law no. 121 of 18.05.2012 on mental health (which has only 1 mention of “suicide attempt” and National 5-years Programs, which describe the Mental Health National actors initiatives, which

[4] Social media “game” that consists of challenges that ultimately ends in the challenge that requires individuals to kill themselves. See https://www.bbc.com/news/world-39729819

have tangency with the area of suicide intervention and suicide prevention. In March 2023, there was a discussion on a new National Mental Health and Wellbeing Law and Plan, which was intended to include more actions on suicide prevention, while influenced by SDGs, but from the existent drafts the lack of strategic suicide prevention thinking, and approach is still evident.

2. Penal Code is mentioning punishments for determination to suicide and to suicide attempt.
3. Regulations (OMJ343/2022) on medical assistance in the prisons.
4. Regulations (RCA63/2021) on the presentation of suicide places and methods in the media.

Altruism NGO resources for suicide prevention.

1. The volunteer-based www.pentruviata.md Lifeline Chat (over 8,000 conversations), member of Befrienders International
2. Online Lifeline's Volunteers Training School on https://cursuri.mirt.md/ website, created on own experience and methodologies, donated by Samaritans Boston, USA, and Lifeline from Denmark.
3. International Suicide Prevention Day, September 10, every year since 2012 in our capital, Chisinau.
4. Myrtle Centre for Counselling and Research in Suicide Prevention (www.mirt.md) with resources and actions for public, professionals and media:
    a. A movie, Cloud 9, based on the cases from the www.pentruviata.md lifeline chat. It has English subtitles. https://www.youtube.com/watch?v=5eTBdW9YVCU
    b. Promos, videos for the school lessons, International Suicide Prevention Day videos, etc. on https://www.youtube.com/@pentruviatamd/videos
    c. A guide for media was created with tips on public reflection of the suicide topic https://mirt.md/ghid-pentru-presa/
    d. Research "Basic milestones for creating the framework for development of suicidal thinking and action in the Republic of Moldova" https://mirt.md/repere (produced by Altruism NGO leader, Liuba Ceban after research at Suicidology Research Center in 2019 in Paris, France).
    e. Trainings, conferences for professionals and distribution of information materials.
    f. Community outreaches, awareness events for schools, NGOs, churches, workplaces, etc.

Limited initiatives, myths around suicide, and almost non-existent recognition of the need for strategic approach have hindered the country's ability to comprehensively address the suicide prevention needs of its population. However, the existent initiatives of Altruism NGO, mental health reforms, public efforts of the classic and new media, as well as the SDGs are driving the authorities to pay attention to suicide prevention in R. Moldova.

Netherlands

Netherlands age-standardised suicide rates per 100,000 (2019) people:

- Both sexes: 9.3
- Female: 6.1
- Male: 12.5

Gerdien Franx and Dr Derek de Beurs contributed to the presentation. The Netherlands government made suicide prevention a formal goal of national policy and thereto launched its first suicide prevention strategy in 2014. There were three notable initiatives towards suicide prevention before 2014:

1. The Ministry of Transportation sponsored the installation of safety measures at train stations and railways, creating awareness, and developing soft skills amongst staff to prevent suicide attempts.
2. The Ministry of Health initiated the online helpline (113 suicide prevention) in 2009.
3. A €3.2 million suicide prevention research program was initiated in 2015 and will receive a follow up of €2 million in 2023.

These three national initiatives have substantially pushed suicide prevention awareness, research, policy, and practice in the whole country. Currently the third national strategy, a five-year program with a budget of €25 million, connects 50 partner organisations that work towards suicide prevention by implementing WHO recommendations in a range of areas.
The main components of the national strategy are evidence-based school interventions, gatekeeper training, building effective suicide prevention capacity in healthcare, and preventing access to means. The national helpline and centre of expertise, 113 suicide prevention, coordinates and monitors the activities of the national strategy and reports progress and results to ministries and parliament. Thus, suicide prevention has become a topic of interest to political parties, which has helped maintain a sense of urgency in society. This is further strengthened by day-to-day collaboration with the media, with whom we discuss the recommendations of the national media guidelines.

Moving from the national level to a regional and local level, healthcare organisations, communities, and consumer and carer groups all over the Netherlands have become aware of their roles and responsibilities. Local networks can rely on guidance from 113 suicide prevention while implementing their suicide prevention policy and plans. The model developed by the European Alliance Against Depression serves as guide in this local work. Sixteen large mental healthcare organisations and 20 hospitals have formed action networks for data collection and learning.

Norway

Norway age-standardised suicide rates per 100,000 (2019) people:

- Both sexes: 9.9
- Female: 6.3
- Male: 13.4

Dr Fredrik A. Walby and Prof. Lars Mehlum contributed to the presentation. Norway was among the first countries to establish a national suicide prevention plan back in 1995 and continues to have national plans. Earlier suicide prevention plans were based on advice from key national experts and other opinion leaders. Central elements of previous plans included both a high-risk approach focused on several subgroups with increased or suspected increased risk, as well as a public health approach that focused on increased public awareness, and interventions to reduce barriers to help-seeking. The two most recent plans have seen the government take a more active role.

The current 2020-2025 suicide prevention plan was launched by the government and involves eight ministries. Here, a very broad zero-suicide vision, involving not only health care but all aspects of society, was introduced for the first time. In the planning of the current national strategy, researchers and other stakeholders were less systematically involved in discussions regarding both the topics and content of the plan as well as the establishment of the zero-suicide vision.

The main challenges of the current Norwegian suicide prevention plan are the lack of a systematic knowledge-based approach, lack of specificity and prioritisation of the different elements, as well as financial support that corresponds to the ambitious vision. Current governmental funding directed specifically at the implementation of the plan is around $3 million annually.

Overall evaluation of suicide prevention plans in Norway is feasible through yearly monitoring of the Cause of Death register. Yet, there have been few initiatives aimed at evaluating different components of the previous or current plan, which is an urgent future priority.

Poland

Poland age-standardised suicide rates per 100,000 people (2019):

- Both sexes: 9.3
- Female: 2.4
- Male: 16.5

Dr Anna Baran and Szymon Wojczakowski contributed to the presentation and presented 2021 age-standardised suicide rates per per 100,000 people (2021) from Statistics Poland: both sexes: 12.1, Female: 3.33, Male: 21.39. The Program on Prevention of Suicidal Behaviours in Poland is embedded in the National Health Program for 2021-2025 as an operational objective. It includes:

1. Developing a responsible information policy on suicidal behaviour and the risk factors and protective factors related to them, including media monitoring.
2. Limiting access to methods of suicide in order to reduce the number of suicidal behaviours in all age groups, including supporting initiatives aimed at improving safety in various facilities. For example, bridges, viaducts, railway infrastructure (i.e., railway stations, crossings, platforms) and buildings, as well as taking rational actions around the availability of drugs, medical agents, and other toxic chemicals used for suicidal purposes.
3. Development, implementation and evaluation of universal, indicative, and selective prevention programs aimed at the prevention of suicidal behaviour, adapted to the needs of various populations.
4. Providing access to help in an emotional crisis through access to support via Internet Communication Tools. Task entrusted in the application of procedures, support and helplines, internet counselling centres, helplines, and support lines), adjusted to the needs of people of all ages.
5. Increasing of the knowledge and skills of health care workers, education workers, social welfare workers, uniformed services, clergy, and other professional groups, in the field of early identification of symptoms of suicidal behaviour, and interventions aiming to help people with suicidal behaviours.
6. Increasing knowledge and skills of mass media representatives, in particular journalists, editors, editorial secretaries, and publishers.
7. Monitoring the epidemiological situation, suicidal behaviour, and social attitudes.
8. Conducting research and development activities, including research aimed at monitoring suicidal behaviour in various populations, methods of suicides, as well as research aimed at identifying new and monitoring known risk factors and protective factors. This includes research looking at the impact of the media on suicidal behaviour.
9. Coordination of activities for the prevention of suicidal behaviour specified in the NHP, including the possibility of establishing and running the Office for the Prevention of Suicidal Behaviour by Institute of Psychiatry and Neurology (IPiN) in Warsaw.

The experts from Working Group on Prevention of Suicide and Depression at Public Health Council Ministry of Health and the Polish Association of Suicidology are in close cooperation with representatives

of the Ministry of Health, other ministries, and some public institutions working towards implementing the National Strategy on Prevention of Suicidal Behaviours.

In the years 2023-2025, the Office for the Prevention of Suicidal Behaviour by Institute of Psychiatry and Neurology (IPiN) is working on improving the system for monitoring suicidal behaviour in healthcare facilities, aligning with WHO recommendations. One of Poland's achievements is a real-time suicide and suicide attempts surveillance system allowing for timely registration of suicide and suicide attempts by the Police Headquarters and for more timely allocation of resources to meet urgent needs.

Poland has resources for media professionals and people interviewed in media (e.g., three handbooks, guidelines, and free online educational program for students of media studies). The media are monitored daily for publications that violate the principles of responsible reporting on suicidal behaviour.

Based on the analysis of foreign and Polish prevention programs, experts selected three programs (i.e., SOS Signs of Suicide Prevention Program, Family Based Crisis Intervention, and The Coping Long Term with Active Suicide Program - CLASP), which will be introduced in Poland, as well as a program for carers of chronically ill elderly people. The Office for the Prevention of Suicidal Behaviour has been working on the implementation of programs for prevention of suicidal behaviours in Poland in four groups: school youth aged 13-18 years, people with suicidal thoughts and after suicide attempts, people treated inpatient in psychiatric health care facilities, and carers of chronically ill elderly people.

In 2022, 1,400 people from different target groups in Poland took part in the online webinars and face-to-face trainings "Prevention of suicidal behaviour in the practice of healthcare professionals".

Over 1,000 participants registered to the first edition of an online course called ELLIPSE Gatekeeper+ Course in Suicide Prevention (EG+) was created by eight partners from five countries working with the EU Erasmus+ grant (https://ellipse.12stepsplan.com). This course was available in seven languages on an online platform Navoica.pl owned by Ministry of Science and Education. The second edition of the course should be available in September 2023. The course includes four modules:

a. Module A is about an internet application 12 Steps Safety Plan (https://12stepsplan.com) that constitutes universal horizontal prevention and improves the coping with the difficult life situations, including suicide thoughts.
b. Module B is based on focus group interviews with 300 participants from ten professions working with people in suicidal crisis and students in Poland, Hungary, Austria, Sweden, and Norway.
c. Module C specifies ten competencies required to prevent suicide that a trainee should acquire during studies to increase the chance of saving someone's life in a suicidal situation.

d. Module D contains interviews with world-known researchers from around the world who talk about suicide prevention. All videos are subtitled in English, German, Hungarian, Norwegian, Polish, Ukrainian, and Swedish.

Portugal

Portugal age-standardised suicide rates per 100,000 (2019) people:

- Both sexes: 7.2
- Female: 3.5
- Male: 11.6

Prof. Ricardo Gusmão and Dr Virgínia da Conceição contributed to the presentation. Portugal had a Suicide Prevention Plan for 2013-2017, but no consistent strategic vision, measurable objectives, or previewed outcome evaluation. Until recently, there was no national plan and/or strategy. However, the National Coordination of Mental Health Policies (NCMHP), linked to the Ministry of Health, started the process, and displayed the intention to advance in that direction.

Previously, a few activities from the NCMHP were produced but did not reach a significant audience or seem to synergise between them. A digital Suicide Prevention Campaign (https://prevenirsuicidio.pt/) was initiated but it is not an actual campaign in the sense that it addresses self-recruitment of non-profit organizations, addresses media suicidal communications and good practices, as well as posting general population awareness texts within a platform that has scarce usability and limited reach. There is no systematic monitoring.

In general, there were many small, episodic, disconnected, opportunistic interventions taking place and being labelled 'suicide prevention.' Lately, the NCMHP established a working group and adopted essential value-oriented interventions to prompt the community and stakeholders in the same direction. Recent advances include a National Strategy for Suicide Prevention 2030 to be outlined and finished by the end of this year to be implemented for the period 2024-2030.

Romania

Romania age-standardised suicide rates per 100,000 (2019)[5] people:

- Both sexes: 7.3
- Female: 2.4
- Male: 12.6

Dana-Cristina Herta and Prof. Doina Cozman contributed to the presentation. There is no national plan and/or strategy for suicide prevention and no specific governmental measures to address suicide prevention in Romania. The Mental Health Law regulates non-voluntary admission and treatment in acute psychiatric wards for persons who are suicidal. There are no other government regulated measures for suicide risk management.

Suicide prevention is mostly provided by the NGOs. Specifically, the Romanian Alliance for Suicide Prevention (ARPS) that has established partnerships with other NGOs and professional organisations such as the Romanian Association of Psychiatry and Psychotherapy. The main resources provided by ARPS are the volunteer-based crisis line (119) with national coverage since 2013, the SOS email since 2010, and the initiation of the National Suicide Prevention Day in November 2015.

The ARPS members have actively contributed to suicide prevention initiative. They have published guidelines for media coverage of suicidal behaviours (2021), and crisis intervention training guidelines for the volunteers of the Romanian crisis line (2021). Further, Members of the ARPS served as expert advisors for a governmental program (2021) and developed a training curriculum focused on depression with suicide risk, which was delivered to psychiatrists, psychiatric nurses and psychologists working in psychiatric hospitals. Finally, a care for the children initiative includes the 119 number for psychosocial emergencies in children and is expected to include mental health awareness classes in schools.

[5] See 2021 suicide rates: https://medichub.ro/reviste-de-specialitate/psihiatru-ro/comportamentul-suicidar- in-perioada-prepandemica-si-intrapandemica-in-romania-i-id-7323-cmsid-66

Serbia

Serbia age-standardised suicide rates per 100,000 (2019)[6] people:

- Both sexes: 7.9
- Female: 3.9
- Male: 12.2

Tanja Bokun and Assistant Prof. Snezana Ukropina contributed to the presentation. Serbia does not have national plan and/or strategy for suicide prevention. However, a national program for the protection of mental health is in place (2019-2026). Compared to a previous program, this current program has precise goals and principles. The main goal is to reform of the mental health care system in Serbia and to improve human rights of individuals with psychiatric disorders.

Institutions that are involved in prevention and treatment are psychiatric hospitals, institutes for mental health, institutes for public health, and primary health care centres. The leading psychiatric hospital in Belgrade, "Dr Laza Lazarevic" opened in 2018. In 2020, a national, toll-free SOS line for suicide prevention started. They also developed an app called "Always for You" that offers training materials and screening tests.

Center "Srce" is NGO, registered charity founded in 1991 and remains the only organisation specifically focused on suicide prevention. It is part of the network Befrienders Worldwide and voluntarily operates phone, email, and chat services. “Srce” trainings are offered mostly to schools, universities, other NGOs, corporate sector, and medical professionals. During the last two years, "Srce" is educating journalists on topics regarding responsible reporting about suicide. It is collaborating closely with Institute for Public Health of Vojvodina, especially regarding activities during Suicide Prevention Day and suicide prevention in primary care.

[6] The suicide rate in Serbia was reduced by 35% in the last 20 years (from 20.1 to 12.2 per 100,000 people).

Slovak Republic

Slovak Republic age-standardised suicide rates per 100,000 (2019) people:

- Both sexes: 9.3
- Female: 2.6
- Male: 16.7

Dr Veronika Tóthová and MArtin Letko contributed to the presentation. State provided data from 2021 is currently available, collected by the National Centre for Healthcare Information (NCZI). In the Slovak Republic in 2021, there was a change in the declining trend and the number of completed suicides increased year-on-year. 548 suicides were recorded (10.1/100,000 population), an increase of 59 more than in the previous year, an increase of 12.1%. Regarding gender, male suicides were significantly more prevalent (81.9%) than female suicides (18.1%). In 2021, 660 suicide attempts were reported, an increase of four reported attempts than in the previous year. The number of male suicide attempts fell by 20 cases, while the number of attempts of women increased by 24 cases. In terms of proportion, women slightly outnumbered men (52.4%) over men (47.6 %). The reason why we consider the statistics a “crooked look” at the situation is due to us having our own statistics for our services, which tells a different story of how many people need help compared to the national data.

Currently, Slovakia lacks any kind of strategic plan or national concept to systematically address the topic of suicide prevention. We find ourselves in a situation when access to state-provided psychological and psychiatric help is lacking due to the shortage of professional capacities. Prevention, awareness-raising activities, public discussions on the subject and the implementation of preventive measures are mostly activities of non-profit and civil society organisations.

As an organisation, we in IPčko are trying to fill this gap in the system and offer services where people in suicidal crisis can reach out. We operate a free 24/7 crisis helpline through different communication channels to make it as accessible as possible (via chat, phone, video chat, and email). We also offer in-person individual sessions through a network of crisis intervention centres (Káčko) and a crisis outreach team (KITIP) that operate in the field to personally help people in crisis.

Slovenia

Slovenia age-standardised suicide rates per 100,000 (2019) people:

- Both sexes: 14.0
- Female: 5.5
- Male: 22.7

Dr Vita Postuvan and Dr Nuša Šedivy contributed to the presentation. Several activities have been ongoing that are now also summarised in Resolution on Mental Health (MIRA) established on 27 March 2018. The program aims to enhance individual and societal well-being over the ten-year period leading up to 2028. While focusing on mental health care, it also extends to encompass preventive measures, particularly in suicide prevention. Specific objectives and measures in this regard are:

- Objective 1: Raising of mental health awareness and literacy, particularly in relation to suicide

Programs have been initiated to identify and take early action in response to suicidal behaviour. A standardised psychological first-aid program has been introduced, disseminating crucial knowledge about causes, symptoms, and signs of suicidal behaviour. Additionally, information on suicidal behaviour and prevention is actively disseminated among different population groups through talks and workshops.

- Objective 2: Early identification of people at risk

Efforts are underway to enable specialists to identify and take early action in response to suicidal behaviour across various population groups. Frontline workers receive continuous education to enhance their ability to identify and respond to suicidal behaviour.

- Objective 3: Access to help and mental health provision for people at risk of suicide

Programs for help and active monitoring of those at risk of suicide are being developed and implemented. These include priority access to clinical psychology, psychiatric and psychotherapy treatment, emergency/first-aid services, clinics for acute cases, and continuous/long-term help or monitoring following a suicide attempt. Continuous cooperation between health services, social services, and the non-governmental sector is emphasised and supported.

- Objective 4: Reduction in alcohol use

To address one of the risk factors associated with suicidal behaviour, measures are being implemented to reduce the consequences of harmful alcohol use and alcohol dependence.

- Objective 5: Restriction of access to the means of suicide

Legislation is under review to ensure safe environments and restricted access to technical means and devices used in suicide attempts. Safety measures, such as fencing at critical points like railway crossings

and high buildings, are being implemented. Moreover, safe spaces are being provided at hospitals, prisons, and other institutions where the suicide risk is higher.

Despite these efforts, limitation of MIRA lies in the implementation of these goals. They are centralised around health care and the National Institute of Public Health. This financial constraint may hinder inclusivity and accessibility, affecting the program's effectiveness. However, in addition to MIRA, various preventive-intervention projects (e.g., Posvet, A (se) štekaš?!?, Živ?Živ!) are conducted nationally. Also, research at the Slovenian Centre for Suicide Research contributes to a holistic approach in understanding and combating suicidal behaviour in Slovenia. To enhance effectiveness, future considerations should explore broader funding strategies for a more comprehensive suicide prevention approach in the country.

Spain (Euskadi)

Spain age-standardised suicide rates per 100,000 (2019) people:

- Both sexes: 5.3
- Female: 2.8
- Male: 7.9

Prof. Alexander Muela led the presentation. Spain does not have a national plan and/or strategy for the prevention of suicide. However, there are suicide prevention strategies that are promoted by certain autonomous communities.

The Strategy for Suicide Prevention in the Basque Country (Euskadi) was published in 2019. It contains nine areas of action. Each area has several measures or actions that cover the prevention, approach, and intervention of suicidal behaviour. The Strategy is currently being successfully developed through various initiatives. For example, in 2022, the first suicide prevention protocol for schools was published and will be officially applied in all public schools in the Basque Autonomous Community. Likewise, preventive interventions of a gatekeeper nature have been developed in the community and university areas. Finally, in health, an intervention program has been developed for the treatment of suicidal behaviour in public health centres. The following are the nine areas of action:

1. Coordination and monitoring of the Strategy.
2. Epidemiological surveillance and research.
3. Information and awareness-raising.
4. Access to lethal means.
5. Emergencies and first intervention.
6. Community level
    - 6.1. Education
    - 6.2. Social services system.
    - 6.3. Labour sphere.
    - 6.4. Family sphere.
7. Health care.
    - 7.1. General health care.
    - 7.2. Primary health care.
    - 7.3. Mental health.
    - 7.4. General hospital.
    - 7.5. Community pharmacy.
8. Postvention.
9. Vulnerable groups.

Uzbekistan

Serbia age-standardised suicide rates per 100,000 (2019) people:

- Both sexes: 8.3
- Female: 4.9
- Male: 11.8

Associate Prof. Agzamova Elena Yurievna and Dr Gulnora Alievna Bogdalova contributed to the presentation. Uzbekistan does not have a national suicide prevention plan and/or strategy. Suicide prevention is a complex problem, and it is not customary to talk about it openly. Typically, such work is conducted, but is associated with the promotion of values, sports, a healthy lifestyle, etc. rather than "suicide prevention". The Ministry of Health lead this work within the framework of other Ministries, such as education, defence, national guard, internal affairs, and other law enforcement agencies and structures.

Challenges include:

1. Development of the National Suicide Prevention Program with the participation of specialists from various fields.
2. Creation of centres for people of different ages, where mental health issues and various psychological programs could contribute to assist in the prevention of suicide and help towards solving difficult personal and family problems.
3. Training of specialists who know the methodology of crisis intervention and preventive work with suicides.

Wales

Wales age-standardised suicide rates per 100,000 (2021; Samaritans) people:

- Both sexes: 12.2
- Female: 5.8
- Male: 18.8

Claire Cotter contributed to the presentation. National strategy (2015-2020) called Talk to me 2 (suicide and self-harm prevention). Extended during COVID to 2022. Currently preparing for the next 10-year strategy from 2024. A dedicated national workforce has been supporting strategy implementation since mid-2020, with a programme management office now hosted by the NHS Wales Executive and funded by Welsh Government.

Since 2020, the national programme team has been able to drive and support the development of a national surveillance system for suspected suicides based on monthly reports from the four Welsh Police Forces, linked to a UK-wide system led by the British Transport Police. This system is helping us to better understand the groups and communities most affected by suicide, building on the data available through the Office for National Statistics suicide bulletins.

Priority workstreams for the new team have included the development of a digital platform to facilitate access to learning and development offers, and to share conference and webinar outputs; a public consultation on guidance around a systems response to people affected, exposed or bereaved by a suspected suicide, and associated activity including the procurement of a national advisory and liaison service (postvention support); and the digitisation of the Help is at Hand Cymru resource.

Postvention work has been partly based on insights work carried out to better understand the needs of those bereaved by suicide in Wales, focussed on the experiences of adults. The Wales Health and Care Research Centre conducted a rapid evidence review on existing interventions that support children and young people bereaved by suicide of a family member, concluding that further research is needed. Work is now underway, working with the Childhood Bereavement Network (CBN) and Support After Suicide Partnership (SASP) to better understand the needs of children and young people directly affected by suicide through further insights work.

In October 2019, the National Advisory Group for suicide and self-harm prevention published guidance on responding to issues of self-harm and thoughts of suicide in children and young people. Professor Ann John, based at Swansea University, conducts research around self-harm and suicide, and the mental health of children and young people, and some of this is referenced on the 'evidence' page of the national digital platform. Situational analysis work is currently underway focussing on male suicide in Wales, and responses to suicide and self-harm in Primary Care.

Summary report produced by Luke T. Bayliss, Seimon Williams, Prof. Steve Platt, and Prof. Thomas Niederkrotenthaler

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