JA ImpleMENTAL

NATIONAL PUBLIC HEALTH ORGANIZATION

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Country Profile "GREECE"

Suicide and Suicide Prevention: Key Facts and National Priorities

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Contents

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Introduction

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

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

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

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

1 Context

1.1 Country, Health and Social System

Greece is a presidential parliamentary republic, administratively divided in 13 regions and located in southeastern Europe at the southern end of the Balkan peninsula. It has a population of 10 459 782 and its capital -and largest city- is Athens with 3 792 469 inhabitants. It borders to the northwest with Albania, to the north with North Macedonia and Bulgaria, to the northeast and east (by sea) with Turkey. Greece has a rich historic al heritage, which is reflected in the 18 UNESCO World Heritage Sites located on its territory. Although Greece faced a serious ten-year financial crisis (2009-2019) due to the global economic crisis, it is classified among high-income countries according GDP per capita (1).

Table 1: Population structure: 2022, expressed as number of persons, by age group and sex (2)

	Sex		
Age group	male	female	**total**
<18	901 076	847 644	1 748 720
18 - 64	3 162 242	3 175 667	6 337 909
65+	1 051 429	1 321 724	2 373 153
Total	**5 114 747**	**5 345 035**	**10 459 782**

Healthy life expectancy at birth is 76.8 (males: 74.9 / females: 78.7) and 16.4 at age 65 (males: 15.6 / females: 17.2) (3). A total of 26.3% of the population is at risk of poverty and social exclusion (4). Income inequality, expressed as the Gini coefficient, is 31.4 (5) and total healthcare expenditure relative to GDP is 9.51% (6).

Overall, the Greek population enjoys good health, with a higher life expectancy than the European average. Extensive health system reforms have been ongoing since 2010, including the strengthening and expansion of public primary care services. There has also been reinvigorated focus on prevention and tackling risk factors through a new national public health plan. Challenges remain in ensuring accessibility and affordability of care, particularly in light of high out-of-pocket payments and the impact of the pandemic. Life expectancy in Greece in 2020 was about half a year higher than the EU average, although it fell temporarily by six months between 2019 and 2020 due to COVID-19 related deaths. The leading causes of death in 2018 were ischaemic heart disease, stroke and lung cancer. Prior to the pandemic, self-reported good health among the population was high, but Greek adults reported higher psychological distress than the EU average [7]

1.2 Mental Health System

For most of the 20th century, psychiatric care in Greece was traditionally provided in big Psychiatric Hospitals. Nonetheless, in 1984, the reorganization and modernization of the mental care system began with the support of the European Economic Community; but it was not until the 1990s that these efforts were officialised and systemised so as to acquire the characteristics of an institutional reform. In 1997, the European Union approved and financed the first National (Action) Plan for Mental Health (i.e. the first phase of "Psyhargos" program) which aimed to keep the pace and momentum of deinsitutionalisation with greater emphasis on psychosocial rehabilitation, social reintegration and vocational rehabilitation for people with mental health problems as well as on raising awareness about mental health issues in the general population. In the years 2001 - 2009 the initial National Plan was revised, as it was deemed overambitious, leading to the formulation of the second National (Action) Plan for Mental Health (i.e. second phase of “Psychargos” program). In the time period 2011-2020, the third National (Action) Plan for Mental Health was drawn up (third phase of "Psyhargos" Program) structured along three axes of action: a) development of services in the community, so as to cover all the needs of each Sector of Mental Health (ToPSY), organized by region on the basis of prefecture and sector, b) mental health promotion and prevention of ill mental health in the general population and c) organization of the mental health care system (sectorization, monitoring, evaluation), research and staff training [8].

Following the recommendations derived from a rapid assessment of mental health services in Greece, conducted jointly by the Ministry of Health and the World Health Organization, as well as valuable lessons from the pandemic, a new National Committee on mental health was established in 2021, consisting of 35 members with vast experience in various areas of mental health. As a result of the workings of this Committee, the fourth National (Action) Plan for Mental Health was formulated, covering the period 2021-2030 (but published in 2023). The plan entailed the following 10 axes, aiming: i) to complete the process of abolishing institutional care; ii) to develop further and finalize the community network of mental health services (MHS), including the integration of mental health in primary health care; iii) to finalise the community network of MHS for children & adolescents; iv) to reform forensic psychiatric services; v) to expand the Network of Limited Liability Social Cooperatives; vi) to ensure the implementation of sectorization of MHS; vii) to curb involuntary hospitalizations to reach the EU average; viii) to facilitate the integration of people with mental health problems in labour

market and protecting employees' mental health; ix) to protect the human rights of people with mental health issues and combat social stigma, x) to include mental health as an integral part of emergency planning for crisis intervention (pandemics, natural disasters, etc.) (8).

More specifically concerning axis 2, mental health services should be digitally connected with primary healthcare services, secondary health care services (hospitals) and tertiary health care services (specialized and psychosocial support services) as well as with welfare services and with municipal support and care services. The interoperability of these services can be achieved through the development of citizen's electronic medical file, where all health issues will be recorded. The electronic medical file is the only coherent way of communicating systems, structures and services, through the needs of each citizen. The continuous recording of health outcomes by updating the data of the individual health file, can be a proposal-method for overcoming the obstacles posed by the fragmentation of the existing mental health services [8].

Primary mental health care services should be a key component of an efficient health system. There is a need for interlinkages between primary and secondary health care services as well as with informal and community-based services. In this way, the essential role of primary mental health care within the overall health system ill be underscored [8].

Furthermore, the development of a monitoring system regarding the progress of the psychiatric reform through the systematization of data collection and processing, aims primarily at mapping the overall picture of the situation and secondly at capturing the developments on an ongoing basis [8].

The Covid-19 pandemic highlighted the existing shortages and needs as well as the imperative need for equal access of all citizens to quality community mental health services. The impact of the pandemic has greatly expanded the need for digital mental health services, as they increase accessibility to services and combat stigma. During Covid-19 period, the Ministry of Health implemented several interventions related to the further development of the community network, the integration of mental health services into primary health care and the use of new digital tools. Indicatively, some of these interventions include: i) the operation of a new nation-wide 24/7 hotline for psychosocial support (10306), ii) recruitment of specialist staff in mental health (psychiatrists, child psychiatrists, mental health nurses), iii) increasing the budget by 62% for mental health and addictions to strengthen existing mental health structures and develop new ones across the territory for all population groups, iv) development of remote psycho-education programs and support for family and caregivers of individuals with autism spectrum disorder, v) completion of development of the digital map of mental health services in order to improve citizens' accessibility to them, vi) development of a tele-psychiatry network in the form of an integrated digital outpatient clinic in remote areas [8].

The total estimated cost of Mental Health services for year 2020, as reflected in the Rapid Assessment of Mental Health Services in Greece, Ministry of Health & WHO, 2020 was €470,366,600 and represents 3.3% of total health expenditure. A necessary and sufficient condition for the smooth and comprehensive implementation of the new national plan is the funding of all proposed interventions. The purpose of detailed estimated budget within the new national Mental Health Plan, is on the one hand the smooth establishment and operation of the new structures and on the other hand the smooth implementation of actions and programs with an emphasis on prevention and promotion of mental health. The estimated budget for the establishment and 18 months of operation is 374.378.500€, and for their subsequent annual operation 362.275.004€ [8].

The forms of government social support for people with severe mental health conditions, include: i) income support (disability >67%), ii) housing support (community residential services by NGOs and public hospitals), iii) employment support (employment quotas and subsidies in public & private sector

and social cooperatives, iv) education support (special schools & special education in mainstream education) and v) legal support (free legal aid for low-income people) [9]. Additionally, the share of people reporting unmet mental health care needs due to financial reasons in 2014 was 9.7% (10).

The proportion of involuntary admissions to Mental Hospitals (4263) to number of total admissions (9803) is 0.43. Furthermore, the proportion of involuntary admissions to psychiatric wards of general hospitals (9861) to number of total admissions (25273) is 0.39. Although the proportion of involuntary admissions to total admissions is high, the proportion of involuntary committed users to 100.000 of population is close to the average in EU [11].

Regarding the follow-up care of people with mental health conditions discharged from hospital in the last year, 25% or less of discharged inpatients received a follow-up outpatient visit within one month. Moreover, the number of community-based/non-hospital mental health (MH) outpatient facilities is 57 while the number of MH outpatient facilities attached to a hospital is 68 and of other outpatient facilities (e.g. Mental health day care or treatment facility) 104. [11]

Table 2: Facilities, number of beds and hospital admissions related to mental health, 2020 [11]

Indicator at national level		number	rate per 100.000 adult/minor population
Mental health hospitals	Facilities	3	0.034
	Beds	*N/A	8.01
	Admissions	*N/A	66.81
Psychiatric wards/units in general hospitals	Wards/units	41	0.464
	Beds	*N/A	6.46
	Admissions	*N/A	237.06
Mental health inpatient facilities specifically for children and adolescents	Facilities	12	0.653
	Beds	*N/A	3.48
	Admissions	*N/A	508.85

*N/A = Not Available

2 Suicide and Suicide Prevention

2.1 Situation Analysis (SA)

2.1.1. Number of suicides, suicide rates and suicide trends

Figure 1: Suicide rate: 2020, by age groups and sex (12)

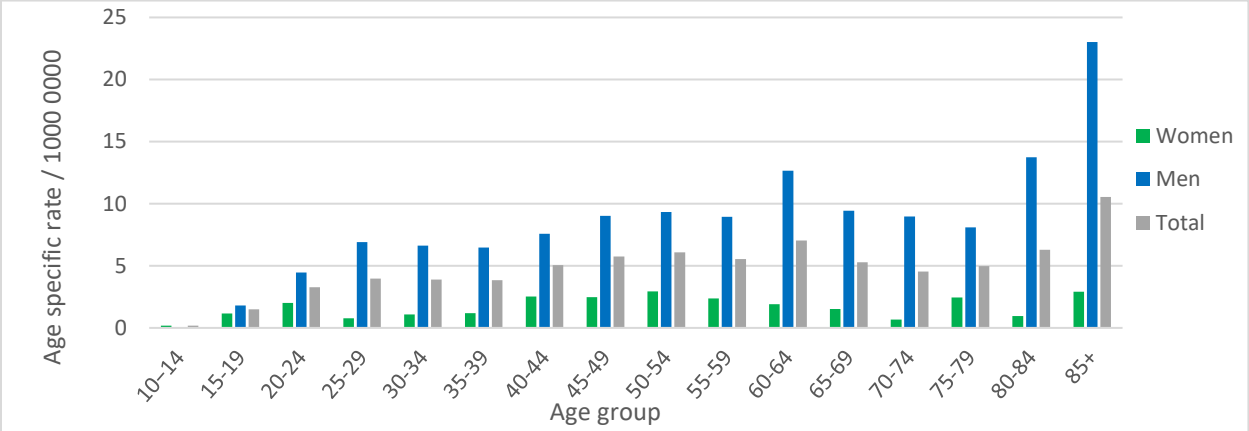

Figure 2: Suicide rates per 100 000 between 2011-2020 by year and sex (13)

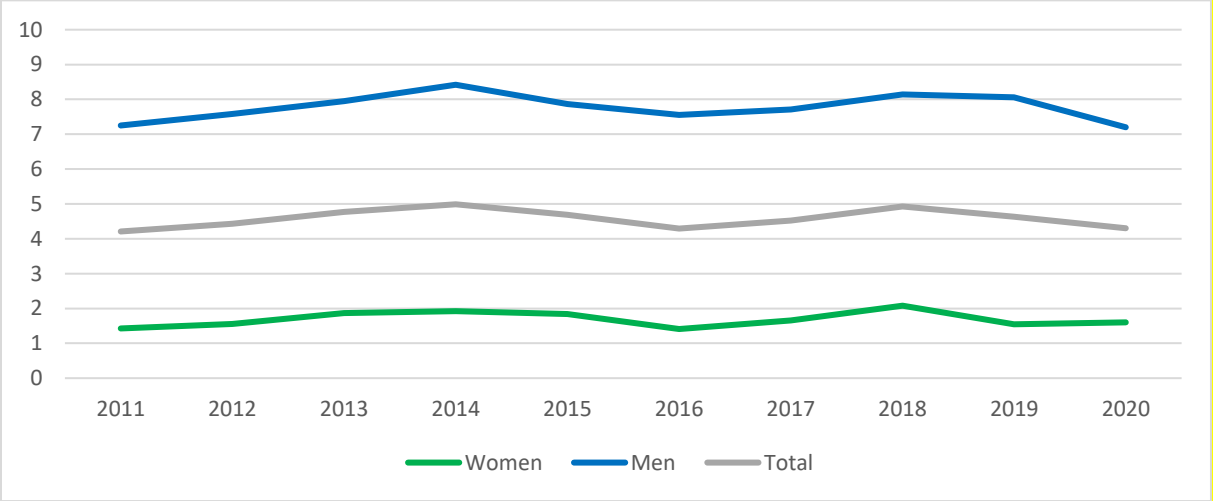

Figure 1 shows that men have higher rates of completed suicides in all age groups than women. Regarding age groups, the highest suicide rates per 100.000 for males appear mainly at older ages, and especially in age groups 85+ (23,015), 80-85 (13,747), 60-64 (12,656), 65-69 (9,441) and 50-54 (9,335). On the contrary, women don't present significant differences in suicide rates per 100.000 for all age groups, with middle age women and women 85+ showing the highest rates (50-54: 2,934 / 40-44: 2,529 / 45-49: 2,486 / 55-59: 2,362 / 85+:2,9). Furthermore, Figure 2 shows that there are no significant differences regarding the trends in suicide deaths for both men and women over the previous decade, with women presenting an almost flat curve due to lower suicide rates compared to men. However, it's worth noting that according the official data of the Hellenic Statistical Authority (ELSTAT), as processed and analyzed by the Suicide Observatory of the NGO "KLIMAKA", during the decade 2010-

2020 suicides in Greece increased by 23%. Specifically, at least 5.557 people ended their lives which corresponds to an average of 500 suicides per year [14].

The Hellenic Statistical Authority (ELSTAT) provides an annual report regarding causes of death according ICD-10 criteria, including deaths from suicide (''intentional self-harm“) per gender and age groups. These data are taken and analyzed by the Suicide Observatory of NGO “KLIMAKA” on monthly and annual basis providing additional data regarding suicide on regional level, methods of suicide and making comparisons with previous time periods.

2.1.2. Methods for suicide

Table 3: Most common methods of suicide at population level (15)

1. Hanging
2. Jumping from height/ in front of a moving object
3. Firearms
4. Self-poisoning
5. Sharp object
6. Smoke, fire and flames
7. Drowning and submersion

Concerning the most common methods of suicide for both sexes and all ages in Greece, hanging and jumping from height/ in front of a moving object are the most common, following by firearms, self-poisoning and sharp objects. The less common are smoke, fire and flames as well as drowning.

2.1.3. Suicide attempts

Table 4: Hospitalization due to self-harm: 2015, by age group and sex (16)

	0-19		20-39		40-59		60-79		80+	
	N	rate	N	rate	N	rate	N	rate	N	rate
female	128	12,4	264	19,3	226	14,1	65	5,4	21	1,8
male	36	3,3	118	8,5	108	7,2	40	3,8	12	1,2

Based on the most recent and available data (Table 4), approximately 1000 people were hospitalized due to self-harm, with females showing significantly higher rates compared to males (69,1% vs 30,9%) for all age groups. The age group 20-39 years old shows the highest hospitalization rate for both sexes (female: 19,3% / male: 8,5%) with self-poising to be the most common method for both sexes and for all ages groups, differing only regarding the type of substances (e.g. sedative-hypnotic, non-opioid analgesics, other psychotropic drugs, alcohol, etc.) (Table 5).

Table 5: Most common methods of self-harm with or without suicidal intent: 2015, by age group and sex (16)

Sex/ Age	0-19	20-39	40-59	60-79	80+
female	1.Self-poisoning (unspecified drugs, pharmaceuticals & biological substances) 2.Self-poisoning (non-opioid analgesics, antipyretics & antirheumatic drugs) 3.Self-poisoning (antiepileptic, sedative-hypnotic, antiparkinsonian and other psychotropic drugs)	1.Self-poisoning (unspecified drugs, pharmaceuticals & biological substances) 2.Self-poisoning (non-opioid analgesics, antipyretics & antirheumatic drugs) 3.Self-poisoning (antiepileptic, sedative-hypnotic, antiparkinsonian and other psychotropic drugs)	1.Self-poisoning (antiepileptic, sedative-hypnotic, antiparkinsonian and other psychotropic drugs) 2.Self-poisoning (unspecified drugs, pharmaceuticals & biological substances) 3.Self-poisoning (non-opioid analgesics, antipyretics & antirheumatic drugs)	1.Self-poisoning (unspecified drugs, pharmaceuticals & biological substances) 2.Self-poisoning (antiepileptic, sedative-hypnotic, antiparkinsonian and other psychotropic drugs) 3.Self-poisoning (other & unspecified chemicals and harmful substances)	1.Self-poisoning (unspecified drugs, pharmaceuticals & biological substances) 2.Self-poisoning (non-opioid analgesics, antipyretics & antirheumatic drugs) 3.Self-poisoning (other & unspecified chemicals and harmful substances)
male	1.Self-poisoning (non-opioid analgesics, antipyretics & antirheumatic drugs) 2.Self-poisoning from alcohol 3.Self-poisoning (unspecified drugs, pharmaceuticals & biological substances)	1.Self-poisoning (unspecified drugs, pharmaceuticals & biological substances) 2.Self-poisoning (antiepileptic, sedative-hypnotic, antiparkinsonian and other psychotropic drugs) 3.Self-poisoning (non-opioid analgesics, antipyretics & antirheumatic drugs)	1.Self-poisoning (unspecified drugs, pharmaceuticals & biological substances) 2.Self-poisoning (antiepileptic, sedative-hypnotic, antiparkinsonian and other psychotropic drugs) 3.Self-poisoning (non-opioid analgesics, antipyretics & antirheumatic drugs)	1.Self-poisoning (unspecified drugs, pharmaceuticals & biological substances) 2.Self-poisoning (antiepileptic, sedative-hypnotic, antiparkinsonian and other psychotropic drugs) 3.Self-poisoning (other & unspecified chemicals and harmful substances)	1.Self-poisoning (other & unspecified chemicals and harmful substances) 2.Self-injury with a sharp object 3. Self-poisoning (antiepileptic, sedative-hypnotic, antiparkinsonian and psychotropic drugs)

2.1.4. Vulnerable groups and help seeking barriers (17, 18, 19)

Box 1. Groups most vulnerable to suicide

According to the most recent available data, men and people aged 50+ are the most vulnerable to suicide. Additionally, high risk groups for suicide are considered persons with psychiatric and psychosocial problems, persons with alcohol and substance use problems, elderly people who live alone and long-term unemployed individuals. Also, adolescents and young people display an increasing trend regarding their suicide rates as compared to previous years. Finally, although there are not any recorded data in Greece concerning LGBTQI+ community, we can assume that they could also be included in high risk groups for suicide according to global data.

Box 2. Most common barriers people face when seeking psychosocial help

- Stigma
- Limited access to mental health services (geographical barriers, long waiting lists for appointment)
- Lack of knowledge of symptoms and where to seek help
- Complexity of mental health system (limited linkages between relative services)
- Lack of experienced staff regarding suicide

2.1.5 National action plan and national activities to prevent suicide

Greece does not have a **national suicide prevention strategy**, although the need for such a national action plan is increasingly raised among the experts. More specifically, the level of actions for Axis 2 in the fourth National (Action) Plan for Mental Health 2021-2030, includes the development and implementation of a suicide prevention strategy as well as the formulation of a National Action Plan for Suicide Prevention [7]; hence, the implementation of the Best Practice SUPRA will contribute towards the goal of drafting a Suicide prevention Strategy.

Nationwide availability of in-person psychosocial/psychiatric crisis services (0-24h) is ensured through the general provision of acute mental health services for assessment and treatment, but standardized follow-up care after an emergency contact (both in- and outpatient services) is not recorded and seems to depend on the service provider.

T**raining for gatekeepers is usually incorporated in existing curricula of professional training eg GPs or it is provided by** different stakeholders at national or regional level; however, this should be systematized and upscaled.

In Greece, since 2007, there is a **nation-wide 24/7 hotline for crisis intervention/suicide prevention (1018)** from the certified NGO "Klimaka", under the supervision of Ministry of Health. Specifically, the hotline focuses on management of self-destructive tendencies in order to address any short-term risk but also to ensure timely and effective provision of psychiatric and psychological support to the caller and his/her family. Moreover, where it is deemed necessary, scientific staff of the service continue being in touch with the callers and monitor their mental health state [20].

From 2020, was put into operation a **new nation-wide 24/7 hotline for psychosocial support (10306)** in order to tackle the multi-faceted effects of the COVID-19 pandemic, during the period of the first quarantine in Greece. It addresses people of any gender and age who face any mental health issue (i.e. stress, panic attack, depression, bereavement, family issues, etc) while at the same time implements brief empowerment and counseling program (6-10 telephone sessions) and free online psychotherapy program (8 weekly sessions /45-50 min) for people with specific mental health problems (anxiety disorders, mild depression, post-stress traumatic disorder) and severe family, financial and social

problems, with no access to psychotherapy services due to pandemic or geographical, social or other hindrances.

Regarding the **restrictive measures of the means of suicide in Greece**, these focus on: I) Standards on weapons security. In particular, weapons of war are prohibited and also the absence of criminal record and psychiatrist's certificate are prerequisites for the use of hunting weapons. II) Standards and norms for traffic. Specifically, medical certificates are required to issue a driving license [21].

There are in place initiatives for **collaboration with media** concerning suicide reporting recommendations that can be assessed and upscaled, which could contribute positively to suicide prevention. **An inventory of current suicide prevention** projects at national or regional level is not available and limitations in data for prevention and action are identified.

2.2 Needs Assessment (NA)

Based on the results of the Situation Analysis a Needs Assesment using the SWOT Analysis was conducted to explore strengths, weaknesses, opportunities and threats related to suicide prevention in Greece. Needs Assesment was done by the JA ImpleMENTAL team at NPHO.

Table 6.: SWOT Analysis

Strengths	Weakness
1. Political Leadership – Deputy Minster of Mental Health and Addictions 2. Recent rapid risk assessment by the Ministry of Health in Collaboration with WHO 3. New Mental Health Plan including an action for drafting a New Suicide Prevention Strategy and availability of Funding 4. Established Committee for Mental Health 5. Directorate of Mental Health in the Ministry of Health 6. Availability of mapping of mental health services https://bi.moh.gov.gr/mhealthmaps/showmap 7. National coverage for mental health needs through an array of mental health services and units, including services for vulnerable groups 8. A 24-hour nationwide emergency service for mental health crisis management and enhanced network of community based mental health services 9. Psychiatric referrals after attempt (but lack of follow up, 10. Mental Health support and suicide prevention support hotlines available	1. Absence of a suicide prevention strategy 2. Gaps in suicide prevention, early diagnosis, support, referral system and monitoring of continuity of care 3. Lack of a structured standardized gatekeeper training program (GPs, schools) fully implemented 4. Limited geographic coverage of postvention services 5. Potentially inaccurate registration of suicide attempts and suicides. Limitations in data on suicide and suicide attempts 6. Staff shortage 7. Dearth of electronic medical 8. No data on referrals and follow up after emergency contact

11. Increased intersectoral cooperation ministry of health , prisons, municipalities, ministry of culture etc 12. Identified stakeholders in the field of Mental Health and Suicide Prevention 13. Existing restrictions on the use of guns 14. Death registries – ELSTAT (Coded according to ICD-10)	
Opportunities	**Threats**
1. Political support for developing a suicide prevention strategy 2. Collaboration of public health with mental health 3. JA ImpleMENTAL; through networking with international experts and stakeholders on suicide prevention, implementing evidence-based practises; opening up capacity building opportunities in terms of training and sharing of knowledge and expertise 4. Mental Health and suicide prevention among international Public Health Priorities 5. European Commisssion's New comprehensive approach to mental health in 2023 and EU Projects on Mental Health including EAADbest depression and suicide prevention program 6. WHO Guidance 7. Growing social awareness for mental health issues especially after the pandemic	1. Stigma and Social stereotyping reducing accessibility to the mental health services 2. Lack of Human resources 3.Not consistent political support 4. Social determinants : loneliness, exclusion support 5. Climate crisis and its mental health impact

3 Reflection on SANA results

Box 3.

Prioritized measures for implementation

Overarching measure Drafting a New Suicide Prevention Strategy within the New Mental Health Plan 2021-2030

Strategic Area 1 (coordination & organization)

- Meaure 1: Draft new coordinated suicide prevention plan
- Measure 2: Establish a network of stakeholders /advisory committee for drafting the New Suicide Prevention Plan – **Quick Win**
- Measure 3: Conduct Survey on Suicide Prevention Needs and Services in the 7 Health Perfectures and Stakeholders - **Quick Win**

Strategic Area 2 (support and treatment)

- Measure 1: Provide training kit to key professionals according to the training kit developed by wp6 and taking into account existing natonal training initiatives
- Measure 2: Training gatekeepers (GPs and other health care workers in primary care/school teenage teachers/school nurses) including awareness raising and fighting stigma(leading in improvement of services as a long-term goal)
- Measure 3: Training in Crisis Intervention & follow up of people with suicidal behavior/ postvention services based on JA ImpleMENTAL Training (leading in improvement of services as a long-term goal)

Strategic Area 3: Restriction of access to means

- Measure 1: Scale up activities already implemented in railways and metro in collaboration with national stakeholders

Strategic Area 4 (awareness raising and knowledge)

- Measure 1: Organise national awareness conference on suicide prevention- **Quick Win**
- Measure 2: Raise awareness through integration of information based on SUPRA in the NPHO website as well as actions in collaboration with EAADbest Greek team on depression and suicide prevention
- Measure 3: Review of existing media guidance

Strategic Area 5: Quality Assurance/expertise and Data Registries

- Measure 1: Improve data registries on Suicide Prevention based on the JA impleMENTAL training and in collaboration with National Stakeholders
- Measure 2: Develop an inventory on Suicide Prevention activities

4 Next steps

Next Steps for Strategic Area 1: Coordination and Organisation

- Finalize the 1st report, to present it alongside the recommended plan to the national mental health committee, September 2023
- Work with JA ImpleMENTAL wp5 team for further capacity building on drafting the suicide prevention strategy, September 2023- April 2024
- Conduct survey on Suicide Prevention Needs of the 7 Health Prefectures and stakeholders based on a questionnaire developed based on SUPRA, September- November 2023 - Quick Win
- Work with the advisory committee on developing further the suicide prevention actions and services, September 2023 – May 2024
- Finalise Draft on Suicide Prevention including estimated budget until July 2024

Next Steps Strategic Area 2 Support and Treatment

- Liase with the Austrian team to organise Gatekeeper training program September, 2023 – December 2023 – Quick Win
- Provide initial training to gatekeepers on Crisis Intervention & follow up of people with suicidal behaviour in 1st YPE and Attica Prefecture in March 2023
- Organise a national training plan based on lessons learned April 2024- July 2024

Next Steps: Restriction of access to means

- Organise an advisory group and liaise with metro and railways, October 2023- February 2023

Next Steps (awareness raising and knowledge)

- Organise national awareness conference on suicide prevention and JA ImpleMENTAL, April 2024

Next Steps Strategic Area 5: Quality Assurance/expertise and Data Registries

- First steps in developing data registries and M&E in collaboration with national Stakeholders, September 2023- April 2024

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