Country Profile "**Iceland**"

Suicide and Suicide Prevention: Key Facts and National Priorities

Author(s):	Lead author: *Gudrun Jona Gudlaugsdottir* Co-author: *Solrun Osk Larusdottir*
Version:	1.0
Date:	6.7.2023

Contents

This report arises from the Joint Action on Implementation of Best Practices in the area of Mental Health, which has received funding from the European Union through the European Health and Digital Executive Agency (HaDEA) of the European Commission, in the framework of the Health Programme 2014-2020, GRANT NUMBER 101035969 — JA-02-2020. The content of this report represents the views of the author only and is his/her sole responsibility; it cannot be considered to reflect the views of the European Commission and/or the HaDEA or any other body of the European Union. The European Commission and the Agency do not accept any responsibility for use that may be made of the information it contains.

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.

Iceland is participating in one out of two best practice programs, the Austrian suicide prevention programme SUPRA.

1 Context

1.1 Country, Health and Social System

Iceland is an island country in the North Atlantic Ocean. The capital and the only city is Reykjavík. Iceland is a parliamentary democratic republic with an average population of 382.003 in 2022 (1).

Table 1: Average population in 2022 by age and sex (1)

	Sex		
Age group	male	female	**total**
<18	43.415,5	40.756	84.171,5
18 - 64	125.438,5	115.063,5	240.502,0
65+	27.645,0	29.684,5	57.329,5
Total	**196.499,0**	**185.504,0**	**382.003,0**

Life expectancy at birth in Iceland was 83.2 years in 2021, among the highest in Europe. Life expectancy at 65 is 21.9 years for women and 20.5 years for men (2). Income inequality, expressed as the Gini coefficient, is 23.2 (3). Iceland's healthcare expenditure was 9.6% of GDP in 2020 (4), lower

than the EU average, both as a percentage of GPD and per capita (5). The relative poverty rate (percentage of persons living with less than 60 % of median equivalised disposable income) was 8.8% in 2019 (5), well below the EU average. The unemployment rate was 5.5% in 2020 (5).

Iceland's healthcare system is state-centred and largely publicly funded with universal population coverage. The Health Service Act (6) sets out the basic structure of national healthcare services. Parliament, relevant ministries and a mix of public and private service providers are responsible for policy, financing and regulation but care is predominantly publicly provided. Iceland is divided into seven healthcare regions which operate to provide general healthcare services but these regions have no administrative authority or separate revenue streams (7, 8). Access to health care is good overall, only 3% of Icelanders reported unmet needs for medical care in 2018. However, the variations between income groups are larger than in the EU on average and larger than in any other Nordic country (5).

1.2 Mental Health System

Mental health services are intertwined with general health services, social services and the school system. A Policy and Plan of Action in Mental Health up to the Year 2020 was approved by parliament (Althingi) in 2016 (9). A new Mental Health Policy until the Year 2030 was approved in June 2022 and an Action Plan based on the policy is underway (10). In 2019 a report/Action Plan on the promotion of mental health, preventing mental disorders and supporting children and adolescents in schools was published by the Directorate of Health, the Embassy of Education and Culture and the Icelandic Association of local authorities (11). This Action plan is currently being implemented. In 2021, the government estimated spending 13.830 million IKR on mental health and there has been increased funding to the field for the last few years (12).

People with severe mental health conditions often qualify for disability benefits through the Social Insurance Administration and can be eligible for affordable housing, either living independently or with support. Social services are free and available on a municipal level nationwide, they can offer financial aid and housing support as well as counselling and other services (13). Other forms of government social support available for people with severe mental health conditions include employment, education and legal support. However, the share of people reporting unmet mental health care needs due to financial reasons was 33.7% in 2019, much higher than the EU average (14).

Information on the frequency of involuntary admissions is not available, the records are not standardised and not collected. It is estimated that 51-75 % of people with mental health conditions discharged from hospital receive follow-up within one month (15). The number of community-based mental health outpatient facilities in Iceland has increased in recent years, it was reported as 37 in 2020 (15). There are mental health teams for more specialised mental health services in all health regions. A new mental health outpatient service unit for children and adolescents nationwide opened in 2022 (16). There are also several NGO´s that provide mental health services and suicide prevention services in the community. Mental health services are also provided by the private sector.

Table 2: Facilities, number of beds and hospital admissions related to mental health, 2021 (12,17)

Indicator at national level		number	rate per 100.000 adult/minor population
Mental health hospitals	Facilities	1	0.34
	Beds	60	20.5
	Admissions	2100	717.6
Psychiatric wards/units in general hospitals	Wards/units	15	5,13
	Beds	114	38.96
	Admissions	2614*	893.3
Mental health inpatient facilities specifically for children and adolescents	Facilities	1	1.2
	Beds	17	20.3
	Admissions	*Unknown*	

* Average number of admissions 2016-2020 (12)

Psychiatric units are subdivisions of the government run general hospitals apart from a private hospital (partly publicly funded) for alcohol and substance abuse rehabilitation. There are also several specialist subunits/teams for diverse mental health problems, some which have been transferred to the primary health care system in recent years. An accurate and recent number for admissions to the psychiatric department for children and adolescents was not available but annual admissions were 49% higher in January and February 2021 compared to the year before (12). The most common barriers people face when seeking psychosocial help are listed in box 1.

Box 1. Most common barriers people face when seeking psychosocial help **(12)**

- Long waitlists for specialised mental health services
- Lack of qualified mental health specialists
- Grey areas of responsibility between health and social services
- Unequal access to services (language, residence, finances)

2 Suicide and Suicide Prevention

2.1 Situation Analysis (SA)

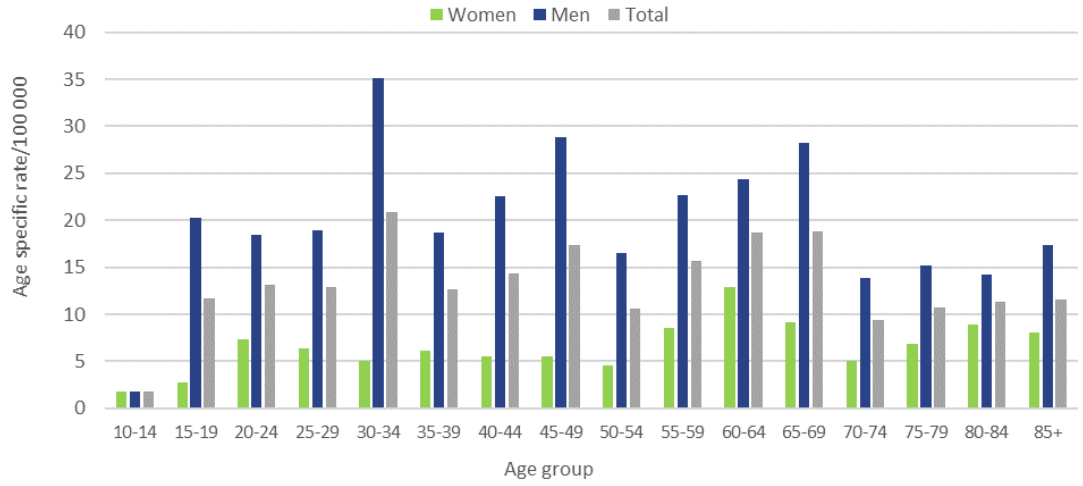
2.1.1 Number of suicides, suicide rates and suicide trends

Statistical data on suicide are published on the website of the Directorate of Health in Iceland where it is available via an interactive dashboard (18). Twice a year a news article on suicide statistics is published on the same website.

Iceland is a small country and suicide numbers are relatively low compared to the largest categories of causes of death (19). Suicide rates fluctuate, ranging from (since the year 1999) 26 suicides per year in 2003 (9.0 deaths per 100.000 population) to 50 suicides in the year 2000 (17.8 deaths per 100.000 population) (18). Because of this, it is important to interpret the numbers of individual years with caution, as there may be a random fluctuation and it is more appropriate to use the averages of

5-10 years. The average number of suicide per year, 2012-2021, was 40 (11.7 deaths per 100.000 population) (18).

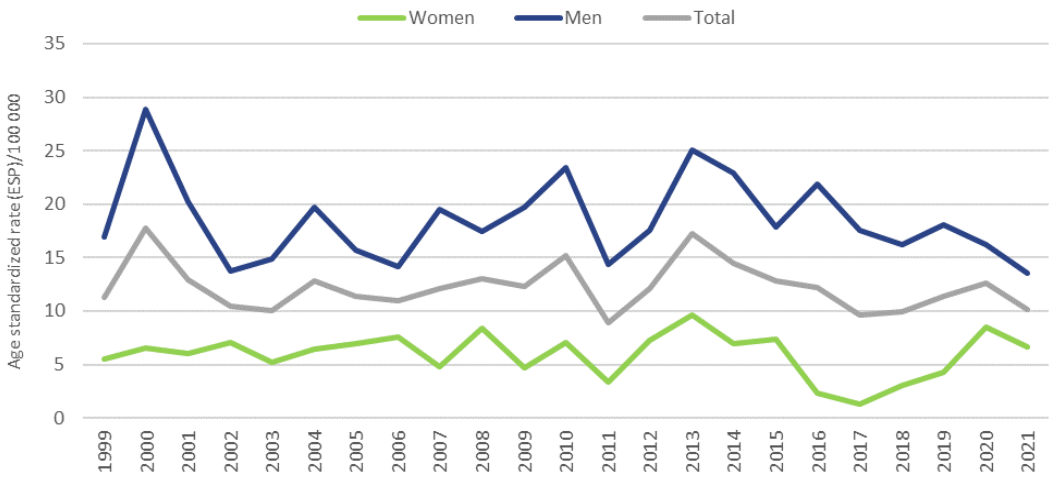
Figure 1: Suicide rate in 2012-2021, by age groups and sex (18).



The relatively high suicide rate in young males and high rate in middle aged males has been of concern. The suicide rate in these age groups has been declining in the past four years. In females, the high suicide rate in the 20-29 year old age groups, compared with the age groups up until age 55 has been of concern.

On average, the suicide rate has been declining in the past 40 years, but the decline has slowed down from the year 2000 onwards, particularly amongst males 25 years and older. This trend has changed in recent years, and the decrease has been sharp from 2020 onwards. The female suicide rate has been low, the lowest in the Nordic countries, but with a sharp upwards swing in the past two years, highest in the 15-24 years old age group. These changes, co-occurring with the onset of COVID-19, may be part of random annual swings found in small populations.

Figure 2. Age standardized suicide rate (per 100 000) by year and sex, 1999-2021. Standardised to the European Standard Population (18,20).



2.1.2 Methods of suicide

Suicides are classified down to the 3-digit ICD-10 code (X60-X84). Table 3 present the most common methods of suicide. Hanging is the most common method used by men of all age groups (59%), prescription drugs or firearms comes next. Hanging is also the most used method among women (45%). Next comes the use of prescription drugs which is the most common method used for the age 40 to 79. During the period 2012-2017 a higher proportion of drowning and submersion was used as a method among women (4.3%) than men (2.2%).

Table 3: Most common methods of suicide by age and sex, for the years 2012-2021 (21)

Sex/Age	0-19	20-39	40-59	60-79	80+
Women	1.Hanging 2.Prescription drugs 3.*	1. Hanging 2. Prescription drugs 3. Drowning and submersion	1. Prescription drugs 2. Hanging 3. Firearm/Sharp object/Jumping from height	1. Prescription drugs 2. Hanging 3. Drowning and submersion	1. Hanging 2. Prescription drugs 3. *
Men	1.Hanging 2.Firearm 3.Jumping from height	1. Hanging 2. Prescription drugs 3. Firearm	1. Hanging 2. Prescription drugs 3. Firearm	1. Hanging 2. Firearm 3. Prescription drugs.	1. Hanging 2. Firearm 3. Sharp object/unspecific means

* No other methods in this age group

2.1.3 Suicide attempts and self harm

When publishing data on suicide behavior in Iceland it is preferred to use the average number for several years because of the possibility of random fluctuation and due to privacy policies. Table 4 presents registration of self harm down to 3-digit ICD-10 codes (X60-X84).

Table 4: Hospitalisation due to self-harm (per 100.000) by age and sex, for the years 2012-2021 (22)

	0-19		20-39		40-59		60-79		80+	
	N	rate	N	rate	N	rate	N	rate	N	rate
Women	82	18,7	90	18,8	50	11,6	8	2,9	2	2.8
Men	14	3,1	60	11,5	30	6,8	6	2,2	0	0

However as there is no nationwide coordinated and agreed registration process when it comes to self-harm, there can be differences between health institutions in methods of data collection and registration. It is not possible using current registration methods to see if self harm was with or without suicidal intent. Therefore, it can not be ensured that the data used reflects the true situation.

Table 5: Most common methods of self-harm by age group and sex for the years 2012-2021 (23)

Sex/Age	0-19	20-39	40-59	60-79	80+
Women	1.Prescription drugs 2.Sharp object 3.Hanging	1.Prescription drugs 2.Sharp object 3.Hanging	1.Prescription drugs 2.Unspecified means/Other specified means 3.Sharp object	1.Prescription drugs*	1.Unspecified means/Other specified means*
Men	1.Prescription drugs 2.Hanging 3.Sharp object	1.Prescription drugs 2.Hanging 3.Sharp object	1.Prescription drugs 2.Hanging 3. Sharp object	1.Prescription drugs 2.Hanging 3.Firearm	1.**

* No other method used
** No self harm registration in this age group

2.1.4 National Suicide Prevention Plan

A **National plan for suicide prevention** was approved in Iceland in 2018 (24). The strategy is based on the current state of scientific knowledge and the successes observed in neighbouring countries. The plan reflects a life-course, whole-of-society view of suicide prevention. The plan consists of six chapters and includes over 54 operations which reach every sector in Icelandic society. These chapters are similar to the six columns in SUPRA. It is still being worked on and 11 out of 54 operations have been completed. Some examples of completed actions from the Action Plan include published media guidelines on responsible media coverage of suicide based on WHO's 2017 "Preventing suicide: a resource for media professionals" (25) and a checklist for environmental safety in psychiatric wards, treatment and residential facilities assessed dangerous to themselves and others (26). There is also a nationwide crisis hotline and online chat which is run by the Red cross in Iceland (27) and a website run in cooperation with institutions, organizations and NGOs that work on suicide prevention. The website, *sjalfsvig.is,* contains educational materials for individuals and professional on self-harm, suicide attempts and postvention with links to helpful sources (28). In Iceland there are nationwide measures restricting the means of suicide including strict gun ownership regulations, laws and regulations and a centralized drug database on prescription drugs and clauses in building regulations and traffic laws.

2.2 Needs Assessment (NA)

The National Council on Suicide Prevention (29) conducted the SWOT analysis on the basis of guiding questions on strengths, weaknesses, opportunities and threats. The results are presented in Table 6.

Table 6: SWOT Analysis

Strengths	Weaknesses/Needs
1. **National Mental Health Strategy and National Suicide Prevention Plan in place since 2018.** 2. Some important operations have been executed, for example; Nationwide 24/7 crisis hotline, suicide hotline and online chat and published guidelines for the Media. 3. Death register - trustworthy, centralised documentation (coded according to ICD-10). 4. Wide network in place. Health promoting approaches at the Directorate of Health includes a wide network of contacts in schools, workplaces and municipalities that can be activated. 5. Small community helps when working towards coordinating procedures (f.ex. educational materials on suicide, suicide risk assessment, after suicide attempt and for postvention). 6. Mental health team operating nationwide, a multidisciplinary team whose goal is to provide services without hospitalisation.	1. Limited number of research projects. Statistically difficult to conduct research due to the small population and relatively few incidents of suicide. 2. Actions included in the National Suicide Prevention Plan are extensive and costly and involve several beneficiaries, several ministries, institutions and organizations. 2. Operations in the National Suicide Prevention Plan are without timelines and performance measures. 3. Small community not helping if discussion of poor quality starts for example on social media, regular reminders of Media guidelines needed.
Opportunities	**Threats**
1. Establishment of Center of suicide prevention with ensured funding for at least one employee, with its own finances and the possibility of obtaining external grants for suicide prevention. 2. Coordinated registration in national medical records for suicide attempts and suicide risk assessment 3. Linking of databases to the death register, analysis of risk factors/risk groups (e.g. demographic parameters, visits to health institutions in the time period before death). 4. Further analysis of at-risk groups, those we know of are difficult to reach, for example males.	1. National Suicide Prevention Plan is not funded, few positions and short-term hires, work goes on top of professionals' other work and projects. 2. Lack of support for people in mild or moderate crises, long waitlists, lack of staff, unclear responsibility, access discrimination between the capital area and the countryside. 3. Stigma against mental illness and suicide.

In the National Suicide Prevention Plan it is stated that in order to ensure success and follow up of actions, **funding for suicide prevention must be secured**, ie by establishing a center of suicide with a permanent job position. This has not been done yet and is one of the biggest opportunity in suicide prevention in Iceland as it is key to systematically working with all relevant stakeholders to reduce the number of suicides and ensure support for those bereaved. Participation in a project such as JA Implemental gives suicide prevention additional weight by connecting with a number of experts in the field on both a European and national level. This provides certain restraint and pushes for an update of the current National Suicide Prevention Plan with setting clear goals, timelines and outcome indicators, but above all highlights the importance of actions being financed.

3 Reflection on SANA results

The following prioritised measures of implementations are based on discussions of SANA results, the SWOT analysis, the current National Suicide Prevention Plan (24) and input from national experts in the field (29). Box 2 reflects prioritised measures and some quick wins which can be worked on in paralell.

Box 2. Prioritised measures for implementation

SUPRA column 1 - Coordination & organisation

- Developing an update to the National Suicide Prevention Plan from 2018, using SUPRA as a model
- Establishment of a Center of Suicide prevention

SUPRA column 2 - Support & treatment

- Implement coordinated procedures on postvention (what happens after suicide)
- Implement coordinated procedures after suicide attempt
- Implement coordinated procedures on suicide risk assessment

SUPRA column 3 - Restriction of means

- Identify and evaluate hot spots for suicide and review the safety regulations for these places

SUPRA column 4 - Awareness & knowledge

- Development and implementation of prizes for individuals or organizations that have worked responsibly on suicide prevention (prevention, intervention and/or postvention) similar to the SUPRA "Papageno Media Prize"
- Developing the idea of a yellow September to raise awareness of the importance of mental health and suicide prevention

SUPRA column 5 - Embedding in prevention & health promotion activities

- Select and fund implementation of an evidence-based approach to suicide prevention in schools for young adolescents (grad

SUPRA column 6 - Quality assurance & expertise

- Promote uniform registration and improved quality of data in databases (as part of coordinated procedures in SUPRA column 2 above)

QUICK WINS

SUPRA column 2 - Support and treatment: Implement procedures for access to and use of opioid antagonists (e.g.Naloxone in spray form)

SUPRA column 4 - Awareness and knowledge: Update online information on suicide, prevention and postvention; revise materials for the bereaved after suicide; publish materials for those who support those bereaved after suicide; publish materials for those who support loved ones after a suicide attempt

As stated earlier several successful actions from the National Suicide Prevention Plan are already completed or underway and are being worked on in diverse systems at national level such as health, education and social affairs. Box 3 reflects the six chapters which all operations in the Plan are linked to, corresponding in part to SUPRA's columns.

Box 3. National Suicide Prevention Plan - chapters

- Mental Health promotion
- Increase knowledge on suicide prevention
- Support grieving loved ones
- Decrease risk among at high risk groups
- Improve quality psychiatric service
- Restrict access to lethal means

Based on missing data in SANA and taking the SWOT analysis into account, the low hanging fruit when it comes to opportunities relate to establishing a coordinated registration process of all suicidal behaviour across health institutions. Data needs to be coordinated across databases to be able to accurately identify at-risk groups. This will then inform prevention strategies and specialised services for at-risk groups. A meeting with stakeholders to take this operation further is scheduled for May 31st 2023.

4 Next steps

A proposal for an Action Plan for the new Mental Health Policy 2023-2030 is currently being discussed in parliament. The proposal includes some components of the National suicide prevention strategy and will hopefully increase commitment to and funding for those actions on a national level.

The next steps which will be worked on within the Directorate of Health are:

- Update the National Suicide Prevention Plan based on SUPRA, adding timelines and performance measures.
- Prioritising operations and identifying quick wins. The network and working groups have been established.
- Starting a dialogue with relevant stakeholders on how to proceed with the issues identified in SANA and through the SWOT analysis regarding identifying at-risk groups and how to reach them (workplaces, schools, social media?). A meeting has been scheduled for the 31st of May.
- Follow up on other operations in the National Suicide Prevention Plan.

5 References

(1) Statistics Iceland. Average population 2022 by sex and age. Retrieved April 28, 2023 from https://px.hagstofa.is/pxen/pxweb/en/Ibuar/Ibuar__mannfjoldi__1_yfirlit__yfirlit_mannfjolda/MAN08000.px

(2) OECD. Life expectancy at 65 (indicator). 2021. Retrieved May 10th, 2023 from https://data.oecd.org/healthstat/life-expectancy-at-65.htm

(3) Eurostat. Gini coefficient of equivalised disposable income - EU-SILC survey. 2018. Retrieved March 10th, 2023, from https://ec.europa.eu/eurostat/databrowser/view/tessi190/default/table?lang=en

(4) Eurostat. Healthcare expenditure statistics. 2020. Retrieved March 30th, 2023 from https://ec.europa.eu/eurostat/statistics-explained/index.php?title=Healthcare_expenditure_statisticS

(5) OECD. State of Health in the EU, Iceland, Country Health Profile. 2021. Retrieved April 5, 2023 from https://health.ec.europa.eu/system/files/2021-12/2021_chp_is_english.pdf

(6) The Health Service Act No.40/2007. Retrieved March 30th, 2023 from https://www.government.is/publications/legislation/lex/2009/09/22/Health-Service-Act-No.-40-2007/

(7) Government of Iceland. Life and health. Retrieved March 30th, 2023 from https://www.government.is/topics/life-and-health/

(8) European Observatory. Country Overview, Iceland. Retrieved March 30th, 2023 from https://eurohealthobservatory.who.int/countries/iceland

(9) Parliamentary resolution on policy and action plan in mental health 2016-2020 (*Icelandic*). Retrieved May 8th, 2023 from https://www.althingi.is/altext/145/s/1217.html

(10) Government of Iceland. Mental health policy until 2030 *(Icelandic)*. Retrieved May 8th, 2023 from www.stjornarradid.is/efst-a-baugi/frettir/stok-frett/2022/06/20/Stefna-i-gedheilbrigdismalum-til-arsins-2030/

(11) Government of Iceland. Report on mental health promotion in schools. 2020 *(Icelandic)*. Retrieved May 8th, 2023 from www.stjornarradid.is/verkefni/fleiri-rit/rit/2020/01/15/Skyrsla-starfshops-um-gedraekt-i-skolum/

(12) The Icelandic National Audit Office. Report on mental health services in Iceland. 2022 *(Icelandic)*. Retrieved March 30th from https://www.rikisend.is/reskjol/files/Skyrslur/2022-gedheilbrigdismal.pdf

(13) Municipalities' Social Services Act No. 40/1991. Retrieved March 30th, 2023 from https://www.government.is/publications/legislation/lex/2008/02/26/Municipalities-Social-Services-Act-No.-40-1991/

(14) Eurostat. Unmet health care needs statistics. 2022. Retrieved March 30th, 2023 from https://ec.europa.eu/eurostat/statistics-explained/SEPDF/cache/37395.pdf

(15) World Health Organization. Mental Health Atlas 2020, Iceland. Retrieved March 30th, 2023 from https://cdn.who.int/media/docs/default-source/mental-health/mental-health-atlas-2020-country-profiles/isl.pdf

(16) Heilsugæsla höfuðborgarsvæðisins (Primary Health Care). Children's Mental Health Centre *(Icelandic)*. Retrieved May 8th, 2023 from www.heilsugaeslan.is/gedheilsa/gedheilsumidstod-barna/

(17) SÁÁ, National Centre of Addiction Medicine (Icelandic). Retrieved April 28th from https://www.saa.is/is/medferd-til-betra-lifs/fyrstu-skrefin/afeitrun-og-greining

(18)Suicide statistics in Iceland. Interactive dashboard. Retrieved May 10th, 2023 from https://island.is/en/tolfraedi-um-sjalfsvig

(19) Causes of death statistics in Iceland. Interactive dashboard. Retrieved May 10th, 2023 from https://island.is/en/danarorsakir-tolur

(20) Eurostat.European Standard Population. Retrieved April 28th, 2023 from https://ec.europa.eu/eurostat/web/products-manuals-and-guidelines/-/ks-ra-13-028

(21) The Directorate of Health Iceland. *Analysis of data on suicides from the Causes of Death Register*. [Unpublished data]. 2023.

(22) The Directorate of Health Iceland. *Analysis of data on Hospitalisation due to self-harm.*[Unpublished data].2023.

(23) The Directorate of Health Iceland. *Analysis of data on most common methods of self-harm*.[Unpublished data]. 2023.
(24) Government of Iceland. National Suicide Prevention Plan. 2018. Retrieved April 30th, 2023 from https://www.stjornarradid.is/lisalib/getfile.aspx?itemid=77110b10-4f85-11e8-942b-005056bc530c%20
(25) The Directorate of Health Iceland. Responsible coverage of suicide in the media - Guidelines. 2019.Retrieved April 30th, 2023 from https://island.is/en/suicide-prevention-strategies/leidbeiningar-fyrir-fjolmidla
(26) Directorate of Health Iceland. Checklist - Safety in psychiatric wards, treatment, and residential facilities for individuals assessed dangerous to themselves and others. 2022. Retrieved April 30th, 2023 from https://island.is/en/suicide-prevention-strategies/oryggisgatlisti
(27) Red Cross in Iceland. National crisis helpline and chat 1717. Retrieved March 30th, 2023 from https://www.raudikrossinn.is/english/projects/domestic-projects/health-and-wellbeing/helpline-1717-and-chat-1717is/
(28) Website on suicide prevention *(Icelandic)*. Retrieved March 30th, 2023 from https://sjalfsvig.is/
(29) Directorate of Health Iceland. Council on Suicide Prevention. Retrieved April 25th, 2023 from https://island.is/en/o/directorate-of-health/councils-and-committees

6 Corresponding authors

Guðrún Jóna Guðlaugsdóttir
Title: Project Manager, Public Health Division, Directorate of Health in Iceland
Address: Katrínartún 2, 105 Reykjavík, Iceland
Email: gudrun.j.gudlaugsdottir@landlaeknir.is
https://island.is/s/landlaeknir

Sólrún Ósk Lárusdóttir
Title: Project Manager, Public Health Division, Directorate of Health in Iceland
Address: Katrínartún 2, 105 Reykjavík, Iceland
Email: solrun.o.larusdottir@landlaeknir.is
https://island.is/s/landlaeknir