Suicide Prevention Action Plan

2025-2027

Suicide Prevention Action Plan 2025-2027

Commissioner for Mental Health
Ministry of Health, Government of Spain

Document approved by the Institutional Committee of the Mental Health Strategy of the National Health System

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Introduction

Mental health is recognised as a public health priority and a fundamental human right by the World Health Organisation (WHO). Growing evidence about the role of social determinants, along with the importance of providing person-centred, human rights-based, recovery-oriented care and services, has led governments around the world to design and implement policies that promote improved mental health for the entire population[1].

According to the WHO Mental Health Action Plan 2013-2030, suicide prevention is highlighted as an international priority, and countries are urged to develop national suicide prevention strategies. It is recognised that many people who attempt suicide belong to groups in vulnerable situations. Additionally, it is noted that suicide rates are often underestimated due to poor surveillance systems or misattribution to accidental deaths. It therefore underlines the need for mental health plans to be comprehensive and to involve not only the health sector but also other sectors[2].

Addressing the serious issue of suicide is at the top of the EU agenda, as reflected in the Council Conclusions on mental health issued in November 2023. The document stresses the need to promote emotional well-being in settings such as educational institutions, workplaces, communities and neighbourhoods. It highlights the importance of implementing a combination of preventive measures and interventions, tailored to the needs of each context, ranging from universal to selective approaches. A strong call is also made to the Member States and the European Commission to intensify their efforts to prevent suicide[3].

Within the framework of the Ley 16/2003, de 28 de mayo, de cohesión y calidad del Sistema Nacional de Salud (Law on Cohesion and Quality of the National Health System), the development of comprehensive strategies and plans to address the most relevant health problems is envisaged. In this context, the Spanish Ministry of Health, in collaboration with the regional administrations, promoted the first Mental Health Strategy of the Sistema Nacional de Salud (National Health System-SNS), published in 2006. The Mental Health Strategy of the National Health System 2022-2026 is currently in force.

The Ministry of Health has been developing various actions to address suicidal behaviour, including the publication of recommendations for the treatment of suicide by the media, which are continuously updated. Additionally, the Ministry has a **Guía de Práctica Clínica de Prevención y Tratamiento de la Conducta Suicida**

1 World Health Organisation (2022). Comprehensive mental health action plan 2013-2030. Geneva. https://iris.who.int/bitstream/handle/10665/345301/9789240031029-eng.pdf?sequence=1

2 World Health Organization (2022). Comprehensive mental health action plan 2013-2030. Geneva.

3 European Union Council (2023). Council Conclusions on mental health. https://data.consilium.europa.eu/doc/document/ST-15971-2023-INIT/es/pdf

(Clinical Practice Guideline on the Prevention and Treatment of Suicidal Behaviour), revised in 2020[4].

In its comprehensive and proactive approach to suicide prevention, the Ministry has structured its efforts through the **Mental Health Action Plan 2022-2024.** This plan is the result of a collaborative effort involving key sectors such as health, education, media, the judiciary and social services.

In this context, **line 4** focuses on prevention, early detection and attention to suicidal behaviour. Among the actions implemented, we should note the creation of the suicide crisis line 024, available 24 hours a day, which provides professional attention and confidential support to people with suicidal behaviour and their families. Additionally, the suicide risk code has been established in the Autonomous Communities to ensure swift and coordinated access to help in crisis situations. Furthermore, tools for risk identification and assessment have been developed, along with continuous training actions for the professionals involved.

In view of this progress, the Ministry of Health recognises the importance of further strengthening initiatives, understanding that suicidal behaviour is a social problem that requires a public health approach. A cohesive structural framework is proposed that covers various aspects, identifies key actors, provides evidence-based activities and promotes coordination, cooperation and service provision, as well as data collection. It also specifies the human and financial resources needed to carry out these interventions.

In this sense, a new Action Plan for Suicide Prevention is presented, which is part of the continuity of previous actions and proposes additional and specific measures. This plan seeks to integrate the expertise of diverse actors and to comprehensively address the challenge of suicidal behaviour in today's society by providing a strong, multidisciplinary support network for both suicidal survivors and survivors of suicide.

This Action lan represents an opportunity to advance the goals of the 2030 Agenda. The implementation of the measures will contribute to achieving Sustainable Development Goal (SDG) 3: Health and Well-being, in particular target 3.4, which aims to reduce premature mortality from non-communicable diseases by one-third through prevention and treatment, and to promote mental health and well-being. In this context, the Instituto Nacional de Estadística (National Statistics Institute-INE) uses the assessment of the mortality rate attributed to cardiovascular diseases, cancer, diabetes, chronic respiratory diseases and, significantly, suicide. Additionally, the measures are expected to promote SDG 5 on gender equality, with the aim of eradicating all forms of discrimination against women and girls worldwide (target 5.1).

4 Grupo de trabajo de la Guía de Práctica Clínica de Prevención y Tratamiento de la Conducta Suicida (2012). Guía de Práctica Clínica de Prevención y Tratamiento de la Conducta Suicida. Plan de Calidad para el Sistema Nacional de Salud del Ministerio de Sanidad, Política Social e Igualdad. Agencia de Evaluación de Tecnologías Sanitarias de Galicia. Guía de Práctica Clínica en el SNS, Avalia-t 2010/02. https://portal.guiasalud.es/wp-content/uploads/2021/05/gpc_481_conducta_suicida_avaliat_compl.pdf

Situation analysis

Barriers to suicide prevention include several challenges affecting the effectiveness of preventive strategies. Some of the main ones are:

1. **Lack of development of surveillance of suicidal behaviour:** The lack of accurate information on suicide attempts, which also ensures interoperability of data, is an obstacle to the development and evaluation of effective strategies.
2. **Low adherence to clinical practice guidelines (CPG):** Evidence-based recommendations are not applied systematically, which increases variability in the care of people with suicidal behaviour.
3. **Lack of continuity of care:** There are gaps in the follow-up of people who are suicidal, affecting their care and recovery.
4. **Suicide stigma:** Myths, biases, prejudices and beliefs persist, which hinder an open discussion on the issue, as well as a low involvement of the media in preventive coverage and awareness-raising.
5. **Lack of a multi-sectoral approach:** Difficulties in coordination between different administrations and sectors limit the effectiveness of preventive strategies.
6. **Limited support and follow up for survivors:** Family members and relatives of people who have died by suicide do not always receive the necessary follow-up and support.
7. **Difficulty in implementing coordinated actions:** As well as exchange of good practices.

Why is a Suicide Prevention Action Plan important?[5]

- It shows the recognition by administrations of the prevention of suicidal behaviour as a public health priority and the need for a shared commitment on the part of society.
- It provides the necessary foundations and coordination, identifying a shared vision and strategic objectives.
- It provides leadership and guidance for the effective implementation of evidence-based activities.
- It identifies the actors responsible for specific tasks and fosters collaboration and coordination.
- It identifies gaps in legislation, service provision and available knowledge.
- It promotes awareness and responsible communication by the media when dealing with suicide.
- It proposes a robust monitoring and evaluation framework to track the achievement of objectives.

5 Modified from Platt, S., Arensman, E., & Rezaeian, M. (2019). National suicide prevention strategies. Progress and challenges. Crisis, 40(2), 75-82. https://doi.org/10.1027/0227-5910/a000587

Epidemiology of suicide

Suicidal behaviour in the world

Internationally, according to the WHO, around 700,000 people take their own lives each year, and many more attempt to do so. These data position suicide as the leading cause of unnatural death and one of the leading causes of mortality in the world. 79% of all suicides occur in low- and middle-income countries.

In 2019, suicide accounted for 1.3% of all deaths, equivalent to a rate of 9 suicides per 100,000 people. This age-standardised rate is higher in men (12.6 per 100,000 people) than in women (5.4 per 100,000 people). In terms of age groups, suicide is the third leading cause of death for young people aged 15 to 19.

The region with the lowest age-standardised suicide rate is the Eastern Mediterranean, with 6.4 per 100,000 people. In contrast, the highest rate is in Africa with 11.2 per 100,000 people (WHO, 2019)[6].

Suicidal behaviour in Europe

Every year, around 50,000 people die by suicide in the European Union (EU). The latest available suicide rate for the EU as a whole was 10.2 per 100,000 people in 2021. As at the global level, this rate is higher in men (16.75 per 100,000 people) than in women (4.55 per 100,000 people).

By country, Slovenia has the highest suicide rate in the EU, followed by Lithuania and Hungary. On the other hand, southern European countries, such as Cyprus and Malta, have the lowest mortality rates (Eurostat)[7].

Suicidal behaviour in Spain

At the national level, according to the National Statistics Institute (INE), there were 4,116 deaths by suicide in 2023. Suicide mortality in Spain in 2023 was 8 deaths per 100,000 people, being higher in males than in females in all age groups. The differences are remarkable, reaching 46.3 suicides per 100,000 men over 90 years of age, compared to 4.4 in women of the same age group[8].

6 World Health Organisation (WHO). (2019) Suicides: facts and figures, 2019 [Internet]. https://www.who.int/es/news-room/fact-sheets/detail/suicide

7 Eurostat. (2023). Deaths by suicide down by almost 14% in a decade. Eurostat. https://ec.europa.eu/eurostat/web/products-eurostat-news/w/edn-

8 Instituto Nacional de Estadística (National Statistics Institute-INE). (2023). www.ine.es

Figure 1. Age-standardised suicide mortality rate per 100,000 people, by sex. Spain, 2013-2023

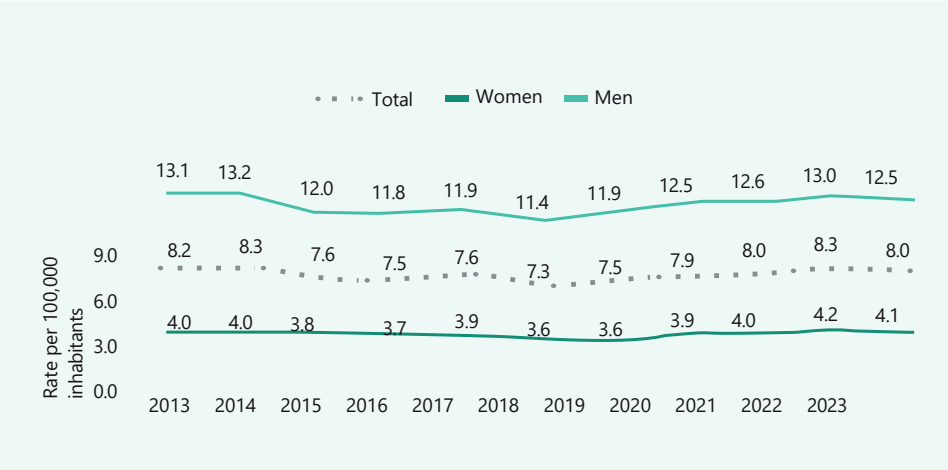
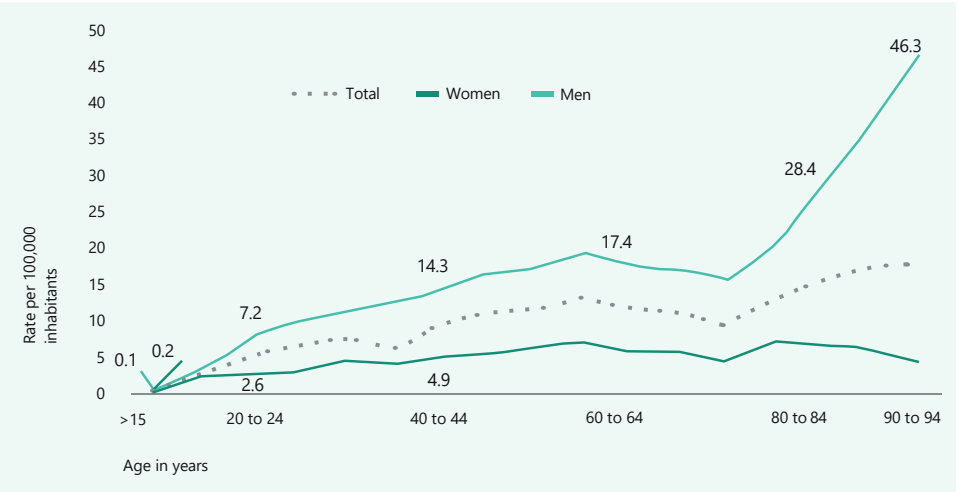


Figure 2. Crude suicide mortality rate per 100,000 people, by age group. Spain, 2023



Typical components of a nationwide suicide prevention intervention[5]

- Monitoring and evaluation.
- Awareness-raising to address stigmatising attitudes towards mental health and suicidal behaviour.
- Leadership and guidance on effective implementation of evidence-based activities.
- Promotion of responsible media coverage.
- Supervision and coordination.
- Improved care and follow-up for survivors of suicide.
- Postvention (interventions with family and relatives after a suicide).

Evidence on the response to suicidal behaviour

Suicide is a complex and multi-causal phenomenon, which makes it difficult to predict, as there is no single determining factor. Previous attempts are a key indicator for the identification of subsequent suicide risk; in fact, a previous attempt is the single most important predictor of suicidal behaviour (WHO, 2014).

The meta-analysis by Franklin et al[9], which covered 365 studies over the past 50 years, revealed that the predictive ability of traditional risk factors for suicidal thoughts and behaviour has been only slightly better than chance. That is, these factors have had little accuracy in anticipating who might develop suicidal thoughts or behaviour. No broad category of factors demonstrated robust predictive ability, and studies have rarely investigated how various risk factors interact with each other, limiting the scope of research. These findings suggest the need to change the current approach from a model focusing on individual risk factors to more complex and accurate models. The authors suggest the use of machine learning-based risk algorithms, which can integrate multiple variables and complex interactions to improve accuracy in prediction and prevention.

Suicidal behaviour is not an illness in itself, but a manifestation of deep emotional distress, which means that it can arise in different contexts without clear signs beforehand. In fact, some people who die by suicide had not previously expressed suicidal ideation or intent[10.]

Despite efforts to stratify suicide risk into levels, traditional predictive approaches have been shown to be insufficient. These methods often generate false positives, leading to unnecessary treatment, and false negatives, which ignore the need for intervention. Moreover, they do not address the dynamic nature of risk or the modifiable factors that could mitigate risk[11].

The most convincing evidence relates to restrictions on access to common methods of suicide, although not all interventions appear to have the same impact. The most effective prevention is associated with structural interventions (such as restricting access to risky places) and restricting access to pharmacological agents.

There is also evidence of effectiveness in setting-based programmes (e.g. in schools, communities, workplaces, prisons, armed forces and police forces), as well as training for primary care physicians and some enhanced care/follow-up interventions[12].

9 Franklin, J. C., Ribeiro, J. D., Fox, K. R., Bentley, K. H., Kleiman, E. M., Huang, X., Musacchio, K. M., Jaroszewski, A. C., Chang, B. P., & Nock, M. K. (2017). Risk factors for suicidal thoughts and behaviors: A meta-analysis of 50 years of research. Psychological Bulletin, 143(2), 187-232. https://doi.org/10.1037/bul0000084

10 Pompili, M., Murri, M. B., Patti, S., Innamorati, M., Lester, D., Girardi, P., & Amore, M. (2016). The communication of suicidal intentions: a meta-analysis. Psychological Medicine, 46(11), 2239-2253

11 Turner, K., Pisani, A. R., Sveticic, J., O'Connor, N., Woerwag-Mehta, S., Burke, K., & Stapelberg, N. J. (2022). The paradox of suicide prevention. International Journal of Environmental Research and Public Health, 19(22), 14983. https://www.mdpi.com/1660-4601/19/22/14983

12 Zalsman, G., Hawton, K., Wasserman, D., van Heeringen, K., Arensman, E., Sarchiapone, M., … Zohar, J. (2016). Suicide prevention strategies revisited: 10-year systematic review. Lancet Psychiatry, 3(7), 646-650. https://doi.org/10.1016/S2215-0366(16)30030-X

The media

Responsible and ethical communication plays an essential role in any suicide prevention plan. The media has the potential to have a positive influence in this area. Through rigorous information, backed by evidence and far from sensationalism, together with the collaboration of specialised professionals, journalism can become a fundamental tool for prevention and awareness-raising.

By broadcasting testimonies of people who have overcome crisis situations and conveying messages of hope, the media can be a support to those going through experiences of extreme suffering. Additionally, it is essential that they provide information about the support resources available to those experiencing suicidal ideation, thus facilitating access to the necessary help[13].

Vulnerable groups

Priority attention is given to several groups in vulnerable situations, who face a higher risk of suicidal behaviour due to social, economic, health or discrimination factors. The WHO and Diaconía Spain's suicide prevention guide identify several groups in a situation of special vulnerability[14].

People with mental health problems[1]. People with mental health problems in crisis situations and especially those with severe conditions that require prolonged support from the social and health care system (severe mental disorders).

People with disabilities[15]. People with disabilities face additional difficulties in accessibility in all environments.

Older people[9]. With a particular focus on those living in social isolation and loneliness, exacerbated by factors such as bereavement, chronic illness and a perceived lack of support.

Adolescents and young people[16]. People experiencing increased emotional suffering for whom it is important to create healthy spaces free of violence.

LGTBIQ+ people[1]. Affected by various forms of stigma, discrimination and violence associated with sexual orientation or gender identity.

People at risk of poverty and social exclusion[17]. Including homeless, precarious or socially vulnerable people.

13 PAHO. Preventing suicide: a resource for media professionals, update 2023 (2023). https://iris.who.int/handle/10665/372691

14 Diaconía Spain. (2023). Guía de prevención del suicidio. https://diaconia.es/wp-content/uploads/2024/01/Guia-prevencion-suicidio-Diaconia-Espana.pdf

15 Observatorio Estatal de la Discapacidad (2021). El suicidio en las personas con discapacidad en España. https://observatoriodeladiscapacidad.info/estudios-estatales/2020/presentacion-del-estudio-el-suicidio-en-las-personas-con-discapacidad-en-espana/oed-suicidio-personas-discapacidad-espana

16 Observación general N.º 15 (2013) sobre el derecho del niño al disfrute del más alto nivel posible de salud (artículo 24). https://www.plataformadeinfancia.org/wp-content/uploads/2018/09/observacion-general-15-derecho-nino-al-disfrute-mas-alto-nivel-posible-de-salud-2013-.pdf

17 Observatorio de la Discapacidad (2024). El suicidio en las personas con discapacidad en España. Retrieved 9 October 2024, from https://www.observatoriodeladiscapacidad.info/wp-content/uploads/OED-Suicidio-personas-discapacidad-Espana.pdf

People who suffer violence[1]. This group includes, among others, physical, psychological or emotional abuse, neglect, harassment, and sexual and gender-based violence.

People with serious illnesses or pain[1]. These conditions may predispose individuals to emotional distress and feelings of hopelessness.

People deprived of their liberty in penitentiary centres. Globally, suicide remains the leading cause of death in prisons. A WHO study reveals that the suicide rate in prisons in Spain is 90.9 per 100,000 persons deprived of liberty, a figure significantly higher than that of the general population.

On the other hand, the identification of protective factors that reduce risk is essential. Access to social support, comprehensive mental health care and community resources are essential.

Family and relatives

The Ministry of Health's "Guía de Práctica Clínica de Prevención y Tratamiento de la Conducta Suicida" (Clinical Practice Guideline on the Prevention and Treatment of Suicidal Behaviour) stresses the importance of providing family members and close associates —such as partners and friends— with the necessary information for appropriate support. This guide suggests establishing a clear plan for seeking help if needed and emphasises the importance of counselling people on how to offer emotional support effectively.

There is also recognition of the need to care for the emotional well-being of family members and loved ones, who often face high levels of stress and suffering in these circumstances[4].

Postvention is essential to promote suicide bereavement management in family members and loved ones, as there is evidence to support its effectiveness. A systematic review by Linde (2017) shows that survivor groups can help to reduce the intensity of grief by providing a space where people feel supported and understood[18].

Community approach

The Pan American Health Organisation's report "Suicide Prevention: Tools for Community Engagement" (2021) underlines the importance of the community in preventing suicide and improving mental health and emotional well-being, both individually and collectively. This approach emphasises the need to involve the community in creating supportive environments that foster emotional well-being and strengthen social bonds, which are essential for effective suicide prevention[19].

Educational environment

Ley Orgánica 8/2021, de 4 de junio, de protección integral a la infancia y la adolescencia frente a la violencia (Organic Law 8/2021 of 4 June on the comprehensive protection of children and adolescents against violence), it establishes a com-

18 Linde, K., & others. (2017). Postvention: A systematic review of the effectiveness of interventions to reduce post-suicidal behaviour in survivors. Cochrane Database of Systematic Reviews.

19 Pan American Health Organization. (2021). Preventing suicide: a community engagement toolkit https://iris.who.int/handle/10665/272860

prehensive protection framework for children and adolescents against violence. Among its measures, it requires the Autonomous Communities to develop action protocols to prevent suicide in the school environment. These protocols establish the systems of communication and coordination between the professionals involved, including the health, judicial and police sectors (Chapter IV, Article 34).

Additionally, Article 35 of the law introduces the role of "Student Welfare Coordinator", the purpose of which is to promote measures to ensure the optimal welfare of children and adolescents, as well as to promote a culture of good treatment[20].

Emergency teams

In recent years, specific protocols have been established for emergency services, including fire brigades, civil protection and law enforcement agencies. These protocols not only precisely define the scope of application, but also delineate the phases of action, the command competencies and the tasks assigned to each participant. Additionally, security measures are included to ensure an effective and safe response to critical situations. This holistic approach seeks to optimise coordination and effectiveness of intervention, thereby contributing to suicide prevention and care for those in crisis situations[21].

Purpose of the Prevention Plan

To reduce and prevent suicidal behaviour in the population through specific actions, with particular care for people in vulnerable situations. This includes providing adequate support, strengthening protection networks and raising awareness in society to reduce the stigma associated with suicide.

It also seeks to improve the equity and cohesion of the National Health System, promoting collaboration between administrations and civil society. The accessibility of aid is guaranteed and the training of professionals involved in this field is prioritised.

Goals[22]

- To improve the availability, timeliness and quality of **information** to effectively plan for the prevention of suicidal behaviour.
- To raise **awareness** of the magnitude of the problem and the effectiveness of available interventions.
- To focus attention on **vulnerable** groups and provide them with specific interventions.
- To reduce the **stigma** associated with suicidal behaviour.
- To address the **social determinants** of health that influence suicide.
- To strengthen multi-sectoral **leadership and participation.**

20 Ley Orgánica 8/2021 de 4 de junio, de protección integral a la infancia y la adolescencia frente a la violencia. Boletín Oficial del Estado (B.O.E.). https://www.boe.es/eli/es/lo/2021/06/04/8/con

21 Municipal, S. P.-P. (n.d.). Protocolo de Actuación Conjunta de los Servicios de Bomberos. Madrid.es. https://www.madrid.es/ficheros/SAMUR/data/217_03b.pdf

22 Modified from United Nations (1996). Prevention of suicide: guidelines for the formulation and implementation of national strategies. New York: The United Nations; 1996

- To improve **access to** suicide prevention services and support for people in crisis or at increased risk of suicidal behaviour.
- To increase the **capacity** of the National Health System to address suicidal behaviour.
- To promote **environmental, community** and social support **factors** to prevent suicide.
- To encourage the implementation of guidelines for responsible **media reporting.**
- To provide adequate support to **family members and relatives** of people affected by suicide.

Funding of the Prevention Plan

At the time of the approval of this plan, and under conditions of budgetary extension, work is being carried out on the relevant budgetary modifications to guarantee adequate funding for the plan, which would be increased in the draft general state budget.

The distribution of credit between the Autonomous Communities and INGESA, as well as the actions subject to funding, will be made in accordance with the criteria that will be debated and worked on in the institutional committee of the Suicide Prevention Action Plan, and subsequently submitted for approval in the Plenary Session of the Consejo Interterritorial del Sistema Nacional de Salud (Interterritorial Council of the National Health System-CISNS). The process of debate and delimitation of funding criteria and actions subject to funding will be carried out during the first quarter of each year that this plan is in force and will be submitted to the plenary session of Interterritorial Council of the National Health System immediately afterwards.

The content of the Interterritorial Council of the National Health System agreements with respect to the distribution of credit to the Autonomous Communities will be included in this plan on an annual basis in the form of annexes.

Methodology

1. **Evidence review** by a group of experts of the scientific literature and suicide prevention schemes nationally and internationally. This review includes the collection of relevant information from sources such as the WHO and the Mental Health Strategy of the National Health System.

2. **Detection of the needs and goals** of the target populations based on this review, taking into account the prevalence of the problem and the response capacity of the National Health System. Additionally, inter-administrative and multi-level coordination has been assessed, including actions implemented regionally and locally.

3. **Definition of the main strategic lines** to meet the prioritised goals. The intervention is mainly distributed on three levels: lines 1 and 2 are universal (targeting the whole population); lines 3 and 4 are selective (targeting groups in vulnerable situations); and lines 5 and 6 are indicated (targeting people who have already attempted suicide). Each line includes specific actions for its implementation, with deadlines, resources and agents involved, which are documented and developed in collaboration with the Driving Group, which is organised into sub-groups corresponding to each of the lines according to the profile of its members. The Driving Group is made up of experts, representatives of institutions, the third sector and users of the National Health System. This group is open and is constantly enriched with new profiles as new needs or areas of action are identified.

4. **Identification of indicators and other actors involved by the Driving Group.** Joint work was carried out to identify and coordinate the agents involved in the Plan's actions, as well as to propose indicators for its evaluation with the Driving Group.

5. **Prioritisation of actions** by the Institutional Committee, which represents the Autonomous Communities, and the Technical Committee, which includes scientific societies and associations of the Mental Health Strategy. They have played a key role in the design of new actions and in the prioritisation of actions to be implemented.

Lines and actions

LINE 1

Quality information

Actions

1.1. Creating a mental health surveillance system within the Red Estatal de Vigilancia en Salud Pública (State Public Health Surveillance Network) that includes suicidal behaviour.

The mental health surveillance system will provide the necessary information to enable decision-making for the prevention of suicidal behaviour. It will collect relevant information on person, place and time, on mental health problems and especially on suicidal behaviour (including suicide attempts and deaths by suicide). Additionally, the inclusion of vulnerable groups and environments (educational, work, rural, urban) will be assessed, identifying critical points where intervention should be prioritised (hotspot locations).

Indicator: Establish, within the framework of the State Public Health Surveillance Network, the Mental Health Surveillance Group to draw up a manual of procedures that defines, among other things, the indicators necessary for the surveillance of suicidal behaviour.

Expected result: Mental health surveillance system procedures manual defining, inter alia, surveillance of suicidal behaviour.

Royal Decree on Mental Health Surveillance, including surveillance of suicidal behaviour.

Responsible body: Ministry of Health.

1.2. Creating an Observatory for Suicide Prevention.

The aim is to analyse and disseminate information on suicidal behaviour, using reliable and homogeneous data. This process will include the collection of detailed information, including reports from the 024 line. Additionally, relevant international, regional and local information will be published. All this information will be integrated into an inter-agency coordination mechanism that will enhance the prevention and care of suicidal behaviour.

Indicator: Agreement establishing the Observatory for Suicide Prevention.

Expected result: Development of reports and establishment of inter-administrative coordination mechanisms in relation to suicidal behaviour.

Responsible body: Ministry of Health.

1.3. Compiling the most relevant scientific research on suicidal behaviour.

A register of ongoing research projects on suicidal behaviour, funded on a competitive basis, will be established. These projects are focused on translational research, with the aim of applying their results to the clinical approach.

Indicator: Publication on the website of the Ministry of Health of the lines of competitive research into suicidal behaviour that are being carried out at the national level.

Expected result: Availability of information on ongoing statewide research projects focused on suicide prevention.

Responsible body: Ministry of Health and Instituto de Salud Carlos III (ISCIII).

1.4. Promoting the recording and monitoring of suicidal behaviour to help improve its surveillance.

The accurate collection of data on suicidal behaviour requires not only an effective system of data collection, but also adequate recording of these data by the relevant administrations. The coordination of the Autonomous Communities can be carried out through the Subcommittee on Information Systems of the Interterritorial Council of the National Health System.

Indicator: % of Autonomous Communities that have worked with the professionals in charge of recording data on suicidal behaviour.

Expected result: Improved recording of previously under-reported indicators of suicidal behaviour.

Responsible body: Autonomous Communities and INGESA.

LINE 2

Awareness-raising

Acciones

2.1. Conducting nationwide awareness-raising, mental health promotion, anti-stigma awareness and suicide prevention campaigns.

Campaigns will be conducted with a community perspective, with a special emphasis on addressing the difficulties of everyday life, as well as identifying the strengths of both individuals and the community. The aim is to strengthen links with a view to promoting emotional well-being, paying special attention to the elderly and other vulnerable groups. Additionally, the dissemination of help resources, such as the 024-suicide crisis line, will be promoted, and the universal accessibility of awareness-raising measures will be ensured.

Indicator: Conducting an annual campaign.

Expected result: Implementation of a campaign and analysis of its impact.

Responsible body: Ministry of Health.

2.2. Developing actions to extend training to the media on how to report suicide and increase its involvement as an agent of prevention.

The Manual of support for professionals will be revised, updated and disseminated. Additionally, actions targeting the media and social media content will be implemented, with the aim of improving the training of journalists in suicide prevention. These actions will include the updating of style manuals and joint work on the identification of suicide prevention focal points in newsrooms.

Indicator: Updating the Practitioner Support and Training Manual.

Expected result: Analysis of the impact of information and training of media managers on suicide prevention.

Responsible body: Ministry of Health.

2.3. Developing health promotion and anti-discrimination campaigns aimed at the prevention of suicidal behaviour with a regional focus.

Suicide prevention campaigns will focus on strengthening coping capacities to deal with emotional distress through a salutogenic approach, promoting health and combating stigma, especially at the regional and local levels. It is also essential to inform citizens about the resources available and the measures that favour accessibility to them.

Indicator: Carrying out a campaign for each Autonomous Community.

Expected result: 100% of the Autonomous Communities carry out campaigns and impact assessment.

Responsible body: Autonomous Communities and INGESA.

LINE 3

Prevention in situations of vulnerability

Actions

3.1. Establishing mechanisms for the identification of people in situations of loneliness who come to the health system, in order to facilitate their link with the community network.

The detection of loneliness should be carried out at different levels of the health care system. Both mental health services and primary care, because of their accessibility, are good places to address this situation. These services facilitate connection to other community resources and promote the integration of people into the local support network.

Indicator: % of Autonomous Communities working to identify people who are in a situation of unwanted loneliness.

Expected result: At least 80% of the Autonomous Communities.

Responsible body: Autonomous Communities and INGESA.

3.2. Establishing initiatives for the promotion of a good state of mental health from a community approach at the local level, paying special attention to the elderly, in order to promote links with their surroundings.

The community level is essential for reaching the most vulnerable groups. It is necessary to promote, from different spheres, the creation of healthier spaces at the local level, especially in suicide prevention.

Indicator: % of Autonomous Communities that have implemented local initiatives, such as workshops or community activities, aimed at promoting emotional well-being.

Expected result: 100% of the Autonomous Communities and impact analysis.

Responsible body: Autonomous Communities and INGESA.

3.3. Providing specialised support to persons with disabilities through a multi-factorial approach.

Providing programmes for people with disabilities is essential to address mental health problems and suicide prevention. It is important to disaggregate these programmes by type of disability. These interventions promote emotional well-being and contribute to holistic care.

Indicator: % of Autonomous Communities with specialised programmes for people with disabilities.

Expected result: 100% of the Autonomous Communities.

Responsible body: Autonomous Communities and INGESA.

3.4. Developing actions for a coordinated approach to situations of violence, focusing particularly on children and adolescents.

Prevention, early identification and early intervention are key to protect against these situations and provide people with comprehensive and coordinated support.

Indicator: % of Autonomous Communities that have promoted interoperability between health, social and equality services, with clear circuits, responding to the detection of cases of violence, including abuse, sexual violence and gender-based violence.

Expected result: At least 80% of the Autonomous Communities.

Responsible body: Autonomous Communities and INGESA.

3.5. Carrying out actions to support and promote non-discrimination towards LGTBIQ+ people, with a focus on the prevention of suicidal behaviour.

Coordination between different areas, awareness-raising campaigns and training for health professionals from a diversity perspective are key to combating discrimination based on sexual orientation and gender identity. These actions help prevent suicidal behaviour by providing a more inclusive environment.

Indicator: % of Autonomous Communities that have carried out programmes aimed at LGTBIQ+ people to contribute to emotional well-being and suicide prevention.

Expected result: At least 80% of the Autonomous Communities.

Responsible body: Autonomous Communities and INGESA.

3.6. Providing support to people at risk of social exclusion and with mental health problems.

This includes, among others, people in situations of displacement, migration or homelessness, as well as children and adolescents who are under guardianship or non-custodial measures requiring comprehensive psychosocial care. These vulnerable groups require a specialised approach that promotes their emotional and social well-being, facilitating their integration and development.

Indicator: % of Autonomous Communities that have established specific resources to support people at risk of social exclusion and with mental health problems.

Expected result: At least 80% of the Autonomous Communities.

Responsible body: Autonomous Communities and INGESA.

3.7. Developing programmes to support caregivers in the provision of care and in the prevention of mental health problems.

Support for caregivers, both formal and informal, is essential in suicide prevention. These caregivers, often exposed to high levels of emotional stress, require resources and accompaniment to preserve their well-being and to be able to offer adequate support to those in need.

Indicator: % of Autonomous Communities with a programme of support, care and/or training for carers.

Expected result: At least 80% of the Autonomous Communities.

Responsible body: Autonomous Communities and INGESA.

3.8. Promoting a gender-sensitive approach for an adequate understanding of and attention to suicidal behaviour.

A gender perspective is fundamental to understanding and addressing suicidal behaviour at every stage of life. In older men, issues such as social isolation and stereotypes of masculinity make emotional expression and access to support difficult, increasing their vulnerability. Factors such as female socialisation with regard to care, emotional expression through the body and poorer living conditions may influence the presentation of differential suicidal behaviour between men and women.

Indicator: % of Autonomous Communities that have programmes with a gender perspective in the treatment of suicidal behaviour.

Expected result: At least 80% of the Autonomous Communities.

Responsible body: Autonomous Communities and INGESA.

3.9. Promoting postvention through support measures for survivors.

Postvention for family members and loved ones after a suicide is key to alleviating grief. Encouraging peer support among survivors and identifying those in need of support in different settings enables early and effective support.

Indicator: % of Autonomous Communities that have established support programmes for survivors.

Expected result: At least 80% of the Autonomous Communities.

Responsible body: Autonomous Communities and INGESA.

LINE 4

Prevention in all policies

Actions

4.1. Limiting access to lethal means.

Limiting access to lethal means, such as firearms and unnecessary drugs, is key to the WHO's LIVE LIFE strategy.

Indicator: Coordination with the Agencia Española de Medicamentos y Productos Sanitarios (Spanish Agency for Medicines and Health Products-AEMPS) and the Ministry of the Interior.

Expected result: Minutes of the coordination meeting and report of agreements.

Responsible body: Ministry of Health.

4.2. Establishing coordination mechanisms with social services for the prevention of suicidal behaviour.

Social and health care provides care and support to individuals and families, with the aim of enhancing autonomy, developing their skills and facilitating their participation in the community. This interdisciplinary approach is fundamental to suicide prevention. In the case of children and adolescents, it is especially important to strengthen protective factors and minimise risk factors in the family environment, based on a positive parenting approach.

Indicator: Establishing regular coordination at the socio-health level to design shared actions between Social Rights and Health.

Expected result: Socio-sanitary coordination meeting minutes.

Responsible body: Ministry of Health.

4.3. Promoting the Health Promoting Schools model.

The school environment is key to the health, comprehensive development and well-being of children and adolescents, and the Escuelas Promotoras de Salud (Health Promoting Schools) model is an effective strategy that facilitates participation and linkage to the educational centre.

Indicator: Coordination of the Health Promoting Schools Working Group of the Ministry of Health with the School Health Working Group of the Ministry of Education, Vocational Training and Sport.

Expected result: Final report of actions and results of the Health Promoting Schools.

Responsible body: Ministry of Health.

4.4. Strengthening cross-sectoral work to promote emotional well-being in schools.

The school environment is key to the health, comprehensive development and well-being of children and adolescents. Cross-sectoral coordination is needed to promote emotional well-being in schools and increase the effectiveness of coordination mechanisms for dealing with experiences of emotional distress in childhood and adolescence.

Indicator: Coordination between the Working Group on child and adolescent mental health of the Ministry of Health and the Working Group on Coexistence/Emotional well-being of the Ministry of Education, Vocational Training and Sport.

Expected result: Final report on actions and results in intersectoral work for the promotion of emotional well-being in schools.

Responsible body: Ministry of Health.

4.5. Promoting mental health in the prison setting, as a means of suicide prevention.

Persons incarcerated in penitentiary institutions require special mental health care. It is essential to implement actions for the detection of suicide risk and access to mental health services, establishing appropriate coordination with community mental health services, in order to promote emotional well-being and thus favour their social insertion-reintegration.

Indicator: Coordination with Penitentiary Institutions and the Community Mental Health Care Network to improve care for suicidal behaviour.

Expected result: Minutes of the coordination meeting between Penitentiary Institutions and the Ministry of Health.

Responsible body: Ministry of Health.

4.6. Accreditation of continuing education for prison professionals in mental health and suicide prevention.

Persons incarcerated in penitentiary institutions require special mental health care. This action will enhance the competences of health professionals working in this field for the detection, prevention of suicide risk, as well as crisis intervention.

Indicator: Presentation of the accreditation proposal to be submitted to the Commission for the Continuing Education of Health Professions.

Expected result: Presentation of the accreditation proposal to be submitted to the Commission for the Continuing Education of Health Professions.

Responsible body: Ministry of Health.

4.7. Considering suicidal behaviour in the framework of occupational health.

Creating healthy workplaces that protect people's well-being is fundamental to suicide prevention.

Indicator: Preparing reports assessing the inclusion of the prevention of suicidal behaviour in occupational risk prevention programmes.

Expected result: Minutes of the Mental Health and Work Working Group, with a specific section on suicide prevention.

Responsible body: Ministry of Health.

4.8. Improving the prevention of psychosocial risks at work.

The identification, assessment and prevention of psychosocial risks in the workplace are fundamental to suicide prevention.

Indicator: Participating in the Grupo de Trabajo Factores Psicosociales de la Comisión Nacional de Seguridad y Salud en el Trabajo (Psychosocial Factors Working Group of the National Commission for Safety and Health at Work-CNSST) with the aim of improving the prevention of psychosocial risks, promoting knowledge, and strengthening information systems and preventive activity in the field of psychosocial factors.

Expected result: Minutes of the CNSST Psychosocial Factors Working Group meetings and action reports.

Responsible body: Ministry of Health.

4.9. Promoting mental health and suicide prevention in the work environment.

The promotion of healthy workplaces and the identification of good practices in emotional health management and mental illness prevention is fundamental to suicide prevention.

Indicator: Strengthening the Red Española de Empresas Saludables (Spanish Network of Healthy Companies) with the aim of promoting the necessary intersectoral and participatory policies that promote the creation of healthy working environments.

Expected result: Minutes of the coordination meetings of the Spanish Network of Healthy Companies and action reports.

Responsible body: Ministry of Health.

4.10. Promoting mental health and suicide prevention in the university environment.

Strengthening collaboration with health care providers is crucial to ensure the emotional well-being of university students. Through the Red Española de Universidades Promotoras de la Salud (Spanish Network of Health Promoting Universities-REUPS), the creation of environments that favour suicide prevention in the academic environment is promoted.

Indicator: Number of targeted activities to promote mental health and suicide prevention at the university.

Expected result: Report on activities to promote mental health and suicide prevention.

Responsible body: Ministry of Health.

4.11. Promoting initiatives aimed at the general population to reduce the prevalence of alcohol and other addictive substances, as well as other addictive behaviours.

The relationship between addictive behaviours and mental health is well documented in the literature and is clearly reflected in the clinical context. Addictions can arise as a consequence of mental health problems, either as compensatory or coping mechanisms, but addictive behaviours can also cause or aggravate mental health problems.

Preventive initiatives and programmes aimed at increasing the risk perception of substance use or other addictive behaviours, reinforcing protective factors and personal skills in the population, or promoting the reduction of substance use and related harm in clinical settings will result in improved mental health.

Indicator: Number of initiatives carried out, and preventive programmes implemented by the Autonomous Communities, Autonomous Cities and INGESA to reduce the prevalence of alcohol consumption and other addictive substances, as well as other behaviours likely to generate addiction.

Expected result: At least 80% of the Autonomous Communities develop initiatives or implement programmes to prevent the consumption of alcohol and other addictive substances, as well as other behaviours likely to generate addiction, both in the clinical context (especially addressing high consumption without dependency criteria in primary care) and in the community and school contexts.

Responsible body: Autonomous Communities and INGESA.

4.12. Strengthening safety at identified hotspots through targeted interventions, including infrastructure improvements and the installation of preventive measures, reducing associated risks and preventing suicide.

The measures envisaged include the installation of physical barriers to restrict access to lethal means and the improvement of the design of public spaces with a security focus.

Indicator: Minutes of the coordination meeting and actions implemented.

Expected result: 100% of the Autonomous Communities have worked on the critical points identified and the impact of these actions has been analysed.

Responsible body: Autonomous Communities and INGESA.

4.13. Encouraging the implementation of psychological autopsies in specific suicide cases.

Psychological autopsies are essential to obtain information for immediate postvention in vulnerable groups. This allows for more effective and fundamental intervention strategies to be designed. More specific cases would be intended for children and adolescents. It can also be envisaged in other settings such as prisons, health services or in the workplace.

Indicator: Autonomous Communities that have carried out psychological autopsies. Number of psychological autopsies performed annually.

Expected result: Establish coordination between Law Enforcement Agencies at the regional level, the Institute of Legal Medicine, Education and Health in order to facilitate the performance of psychological autopsies.

Responsible body: Autonomous Communities and INGESA.

4.14. Establishing frameworks for joint action by health and non-health emergency services.

This framework seeks to improve coordination between emergency services that collaborate with state, regional and local institutions. The aim is to optimise resources and ensure a more effective response to emergency situations.

Indicator: % of Autonomous Communities that have updated rescue protocols for people with suicide attempts by health and non-health emergency services at the local and regional levels.

Expected result: At least 70% of the Autonomous Communities.

Responsible body: Autonomous Communities and INGESA.

4.15. Implementing joint work strategies for suicide prevention in collaboration with social services at the regional and local levels.

Socio-health coordination reinforces comprehensive care to address the social determinants that impact on emotional well-being, especially aimed at older people and groups in vulnerable situations.

Indicator: % of Autonomous Communities that have agreements and/or resources dedicated to intersectoral collaboration in suicide prevention between health and social services.

Expected result: At least 80% of the Autonomous Communities.

Responsible body: Autonomous Communities and INGESA.

LINE 5

Health approach

Actions

5.1. Promoting the exchange of experiences and good practices in the implementation of actions against suicidal behaviour.

This initiative aims to create a learning community to share best practices focused on improving accessibility and care for people at risk of suicide, especially in vulnerable groups. Additionally, it seeks to promote appropriate communication about suicide in the media, the suicide risk code and to promote innovative care projects.

Indicator: Organisation of a day of good practice based on the prevention of suicidal behaviour with those responsible for suicide prevention at the regional level.

Expected result: Analysis of the impact of the day and creation of a permanent working group with those responsible for suicide prevention at the regional level.

Responsible body: Ministry of Health.

5.2. Adapting hospital emergency services with resources to improve care for people experiencing suicidal behaviour.

Mental health emergencies are now central in treating suicidal behaviour. Improving resources in this area helps to optimise multi-professional work, ensuring more effective interventions in crisis situations.

Indicator: % of Autonomous Communities with emergency departments adapted to providing accessible and appropriate care for people exhibiting suicidal behaviour.

Expected result: 100% of Autonomous Communities have implemented it.

Responsible body: Autonomous Communities and INGESA.

5.3. Strengthening the suicide risk code to ensure an integrated process of detection and management.

In order to promote rapid and effective health and community access in situations of suicide risk, it is essential to ensure the immediate availability of help. This allows for adequate follow-up and crisis intervention in an integrated, coordinated and multidisciplinary manner. This approach ensures that health

services and support networks work together to improve accessibility and focus on the needs of people at risk.

Indicator: % of Autonomous Communities that have developed the suicide risk code.

Expected result: 100% of Autonomous Communities have implemented it and have analysed the effectiveness of the measure.

Responsible body: Autonomous Communities and INGESA.

5.4. Establishing community-based programmes for people at risk of suicidal behaviour.

These community-based programmes offer support at times of increased risk, such as after a hospital discharge or a previous attempt. They are especially aimed at people in crisis situations and those with severe mental disorders requiring prolonged support from the social and health care system to promote a comprehensive and personalised recovery.

Indicator: % of Autonomous Communities with community programmes to address suicidal behaviour.

Expected result: At least 70% of Autonomous Communities have implemented it.

Responsible body: Autonomous Communities and INGESA.

5.5. Providing suicide prevention programmes for people with serious illness and/or pain.

Offer programmes for people with severe illness and/or pain to address the associated psychological suffering. These interventions contribute to comprehensive care with the aim of preventing suicide.

Indicator: % of Autonomous Communities with mental health care programmes for people with serious illness and/or pain that prevent suicidal behaviour.

Expected result: At least 70% of Autonomous Communities have implemented it.

Responsible body: Autonomous Communities and INGESA.

LINE 6

Comprehensive approach

Actions

6.1. Promoting the participation of survivors in the design, implementation and evaluation of the Suicide Prevention Plan.

Citizen participation in mental health policy, following the WHO approach, ensures that services reflect people's needs.

Indicator: Minutes of working groups with profiles of survivors (yes/no).

Expected result: Involvement of survivors in the creation, monitoring and evaluation of the Suicide Prevention Plan.

Responsible body: Ministry of Health.

6.2. Improving coordination of the 024-suicide crisis line with other helplines and emergency numbers.

In certain situations, some calls must be referred to the emergency services to ensure immediate intervention. However, it is equally important to move towards a broader and more coordinated approach, with specialised teams and telephone lines integrated into the health services of the Autonomous Communities, which will strengthen comprehensive care throughout the entire care process, guaranteeing an appropriate and continuous response for each person.

Indicator: Establishing at least one agreement between the 024 telephone number and other emergency and assistance telephone numbers of the regional health services.

Expected result: Establishing at least one agreement with a healthcare Autonomous Communities for the coordination of calls.

Responsible body: Ministry of Health.

Promoting the alignment of plans or programmes of the Autonomous Communities and INGESA with the Ministry's Action Plan for Suicide Prevention.

One of the competencies of the Ministry of Health is to establish the bases and general coordination of healthcare, so the Autonomous Communities and INGESA must have suicide prevention plans with a shared orientation.

Indicator: % of aligned Autonomous Communities and Cities that have a Regional Suicide Prevention Plan in place during the financial year 2025-2027.

Expected result: 100% of the Autonomous Communities and Cities have a Regional Suicide Prevention Plan aligned for the 2025-2027 exercise.

Responsible body: Autonomous Communities and INGESA.

6.3. Strengthening teams that can provide specialised and integrated telephone assistance with health services at the regional level.

Developing a network of specialised mental health care teams that can provide care by telephone, coordinated and integrated within the regional health services to improve the approach to people at risk of suicide. Maintaining the 024-suicide crisis line as a single telephone number for Spain, teams with assistance from the Autonomous Communities linked to the care network are used to offer immediate support and ensure adequate follow-up, effectively contributing to suicide prevention.

Indicator: % of Autonomous Communities that have some type of suicide crisis line integrated into the healthcare network.

Expected result: At least two Autonomous Communities have a telephone helpline service integrated into the healthcare network.

Responsible body: Autonomous Communities and INGESA.

6.4. Provide training and supervision for gatekeepers dealing with people at risk of suicide.

Training and case supervision for health professionals is essential in addressing suicidal behaviour. It is also important to train agents from other institutions, who can be the first contact for people at risk of suicide, especially from the educational field, emergency services, as well as other referents who have contact with people in vulnerable situations. The profile of the teachers will be that of experts (including mental health professionals and experts by experience in mental health) in the prevention and tackling of suicidal behaviour.

Indicator: % of the Autonomous Communities with training and/or supervision programmes, including professionals from the health, social and educational services, law enforcement agencies, penitentiary institutions, firefighters, among others, as well as other community referents with contact with people at risk.

Expected result: At least 80% of Autonomous Communities have offered training.

Responsible body: Autonomous Communities and INGESA.

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The final editor of this document is the Ministry of Health. The proposals set out reflect the input of many practitioners, in particular those made by the Institutional Committee and the Technical Committee.

The final text does not necessarily reflect the views of all those involved in the complex drafting process.

The Suicide Prevention Action Plan is intended to be a key tool for building upon prior initiatives and moving forward with the implementation of specific measures. This plan adopts a comprehensive approach to addressing the complexities of suicidal behaviour, a social and public health problem that calls for a collective, continuous and coordinated response.

The result of a collaborative effort, this plan draws on the experience of multiple institutional, professional and community stakeholders, leveraging a robust interdisciplinary network. The plan proposes action in three complementary areas of prevention: universal prevention, targeted at the general public; selective prevention, targeted at groups in vulnerable situations; and indicated prevention, targeted at people who have shown signs of suicidal behaviour.

This plan establishes a comprehensive response to suicide, promoting collaboration between the different areas of action and offering support both to those directly affected and to those close to them.

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